

CERTIFICATE OF DEATH

Reg. Dist. No.

21

8956

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>ANNE ARUNDEL</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>ANNE ARUNDEL General</u>		d. STREET ADDRESS <u>Waterbury Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>SARAH COLE ABRAMS</u>		4. DATE OF DEATH Month Day Year <u>SEPT 10 1956</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 3 - 1880</u>
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Practical Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Balto., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick William Cole</u>		14. MOTHER'S (MAIDEN) NAME <u>Sophie Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mr. George A. Herbert</u>		Address <u>5300 Belleville Ave.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage with left</u> <u>260X</u> DUE TO <u>hemiplegia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>and</u> (c) <u>Diabetes Mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
INTERVAL BETWEEN ONSET AND DEATH <u>Sept 9, 1956</u> <u>11:30 pm</u> <u>Sept 10, 1956</u> <u>11:20</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>September 9, 1956</u> , to <u>Sept 10, 1956</u> that I last saw the deceased alive on <u>Sept 10, 1956</u> , and that death occurred at <u>4:20 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Mannie Klawans</u> M.D.		DATE SIGNED <u>9/10/56</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAUANSKI</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/13/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons - Balto 17, Md</u>		24. REC'D BY REGISTRAR <u>DATE 13 1956</u>	
24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

REG. NO. 11

2102

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. RACE White	
4. DATE OF BIRTH 10-14-1928		5. PLACE OF BIRTH Jackson, Mississippi		6. DATE OF DEATH 4-4-68	
7. PLACE OF DEATH Memphis, Tennessee		8. CAUSE OF DEATH Suicide		9. MANNER OF DEATH Homicide	
10. OCCUPATION Attorney		11. EDUCATION High School		12. RELIGION Methodist	
13. MARITAL STATUS Single		14. PREVIOUS MARRIAGES None		15. SOCIAL SECURITY NO. 1-345-67890	
16. SIGNATURE OF DECEASED (None)		17. SIGNATURE OF WITNESS (None)		18. SIGNATURE OF PHYSICIAN (None)	
19. SIGNATURE OF CORONER (None)		20. SIGNATURE OF JURY (None)		21. SIGNATURE OF JUDGE (None)	
22. SIGNATURE OF COUNTY CLERK (None)		23. SIGNATURE OF STATE CLERK (None)		24. SIGNATURE OF DEPARTMENT OF HEALTH (None)	

BUREAU V. 2

SEP 13 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08947

8977

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 6 mos. 26 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2527 Ridgely St., Mt. Winans, Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 2527 Ridgely Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Thomas Middle Anderson Last Anderson				4. DATE OF DEATH Month 9 Day 5 Year 1956			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1878?	
9. AGE (In years last birthday) 78? yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		IF UNDER 24 HRS. Months — Days — Hours — Min. —			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Walter				10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory failure, hypostatic Pneumonia, 522X DUE TO Pulmonary Edema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 Month, Day, Year p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2/9 , 19 56 , to 9/5 , 19 56 , that I last saw the deceased alive on 9/4 , 19 56 , and that death occurred at 12:24 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 9/5/56 ACTUAL SIGNATURE [Signature] M.D. [Signature] PHYSICIAN'S NAME (Type) Ludwig Benadict							
22a. BURIAL, CREMATION, REMOVE (Specify)		22b. DATE THEREOF 9-10-56		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Balto. City	
23. FUNERAL DIRECTOR'S SIGNATURE [Signature]				ADDRESS 3700 Edmonston Rd. Balt. Md.		24a. REC'D BY REGISTRAR [Signature] DATE 10/1/56	
				24b. REGISTRAR'S SIGNATURE [Signature]			

SEP 10 1956

RECEIVED

BUREAU V. S.

8978

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Meade Heights, Fort George G. Meade</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				d. STREET ADDRESS <u>1733 C. Forrest Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>BAINES</u> Middle <u>Bessie</u> Last <u>Baines</u>				4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3 February 1888</u>	9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Louisiana</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Shephard</u>				14. MOTHER'S MAIDEN NAME <u>Georgia Ann Puckett</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>313-12-5033</u>		17. INFORMANT Address <u>Joseph E. King, 1753 C. Forrest Ave, Ft Meade</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Vremia</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive C-V Disease & Myocardial Infarction</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6 August</u> , 19 <u>56</u> , to <u>15 September</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>15 September</u> , 19 <u>56</u> , and that death occurred at <u>8:15 P.M.</u> , from the causes and on the date stated above. <u>15 September 1956</u> ADDRESS (Street, city or town, state) <u>USAH, Fort George G. Meade, Md.</u> DATE SIGNED <u>15 Sept 56</u>							
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. <u>USAH, Fort George G. Meade, Md.</u>			
PHYSICIAN'S NAME (Type) <u>RAINER S. PAKUSCH, CAPT, MC.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles R. Law</u>				ADDRESS <u>802 Madison Avenue</u>		24a. REC'D BY REGISTRAR DATE <u>17 Sep 56</u>	
				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		W.L. SAYLOR, 1ST LT, MS 'C	

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CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

BUREAU V. 2

SEP 19 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08949

8957

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>a a</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b <u>15 days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Notwell</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>A. A. General</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES</u> <u>BARNETT</u>				4. DATE OF DEATH Month Day Year <u>Sept</u> <u>14</u> <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>?</u>	
9. AGE (In years lost birthday) <u>75</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waterman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Oystering</u>		11. BIRTHPLACE (State or foreign country) <u>Notwell Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Tobias Barnett</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Green</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>John T. Barnett, Upper Marlboro Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Annapolis A.A. Md</u>		20f. (City or town) (County) (State) <u>Annapolis A.A. Md</u>	
21. I certify that I attended the deceased from <u>7-30-56</u> , 19 <u>56</u> , to <u>9-17-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-17-56</u> , 19 <u>56</u> , and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. T. Allen</u>				ADDRESS (Street, city or town, state) <u>62 Cathedral</u>		DATE SIGNED <u>9-19-56</u>	
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>				<u>62 CATHEDRAL ST</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 19 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carters</u>		22d. LOCATION (City, town, or county) (State) <u>Frederick Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard J. J. J. J. J.</u>				ADDRESS <u>Frederick Md.</u>		24a. REC'D BY REGISTRAR DATE <u>9/20/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>J. J. J. J. J.</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES B. BARNETT		DATE OF BIRTH 10-10-1912	
SEX M		RACE W	
MARRIAGE 10-10-1912		DATE OF DEATH 10-10-1912	
PLACE OF BIRTH Baltimore, Md		PLACE OF DEATH Baltimore, Md	
OCCUPATION None		CAUSE OF DEATH None	
DISEASE OR INJURY None		MANNER OF DEATH None	
SIGNATURE OF DECEASED None		SIGNATURE OF WITNESS None	
SIGNATURE OF PHYSICIAN None		SIGNATURE OF CLERK None	
DATE 10-10-1912		TIME None	

BUREAU V. 1

SEP 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8979

CERTIFICATE OF DEATH

09900 26

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS Not given			
3. NAME OF DECEASED (Type or print) First William Middle Bonner Last Bonner				4. DATE OF DEATH Month 9 Day 27 Year 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Not given	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Charles Bonner				14. MOTHER'S MAIDEN NAME Lucy Bonner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 5/23 , 19 55 to 9/27 , 19 56 , that I last saw the deceased alive on 9/27 , 19 56 , and that death occurred at 2 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 9/28/56							
ACTUAL SIGNATURE L. Benedict		M.D. Crownsville, Md.					
PHYSICIAN'S NAME (Type) L. Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10-3-56		22c. NAME OF CEMETERY OR CREMATORY Univ. of Md Medical Sch.		22d. LOCATION (City, town, or county) (State) Baltimore Md	
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, Jr.				ADDRESS Annapolis, Md		24a. REC'D BY REGISTRAR DATE 5 1956	
				24b. REGISTRAR'S SIGNATURE L. M. Joyce			

TO BE RELAYED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08950

8958

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>2 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. NAVAL HOSPITAL, ANNAPOLIS, MD</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Frances</u> Middle <u>Murray</u> Last <u>BRYAN</u>				4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-17-02</u>		9. AGE (In years last birthday) <u>54</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u> </u>		10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>Edward P. Murray</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Agnes Brady</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>U.S. Naval Hospital, Annapolis, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> <u>522</u> <u>154x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Malignant neoplasm of rectum</u> <u>154</u> DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> <u>2 - 3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, <u> </u> Day, <u> </u> Year <u>19</u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>9-8</u> , 19 <u>56</u> , to <u>9-10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-10</u> , 19 <u>56</u> , and that death occurred at <u>4:27 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u> </u> DATE SIGNED <u> </u>							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u> </u>				PHYSICIAN'S NAME (Type) <u>R.K. MOXON CDR MC USN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9-14-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	
22d. LOCATION (City, town, or county) <u>Arlington</u>				22e. (State) <u>Va</u>		22f. (Country) <u> </u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>				23a. ADDRESS <u>Annapolis Md</u>		23b. REC'D BY REGISTRAR <u> </u>	
23c. REGISTRAR'S SIGNATURE <u>[Signature]</u>				23d. DATE <u>SEP 14 1956</u>		23e. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

08951 28
Reg. Dist. No.

8980

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville	c. LENGTH OF STAY IN 1b 14 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS 1032 N. Broadway	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) John		4. DATE OF DEATH 9 26 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/9/84
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	IF UNDER 24 HRS. Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unknown	11. BIRTHPLACE (State or foreign country) North Carolina
12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Plummer Coleman		14. MOTHER'S MAIDEN NAME Chaney Coleman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	17. INFORMANT Hospital Records
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pnenumonia 026x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Luetic Optic Atrophy			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Crownsville, Md.		(County) (State)	
21. I certify that I attended the deceased from 9/13 , 19 56 , to 9/26 , 19 56 , that I last saw the deceased alive on 9/26 , 19 56 , and that death occurred at 2:30 p. M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Randolph Henry Hoff		DATE SIGNED 9/27/56	
PHYSICIAN'S NAME (Type) Randolph Henry Hoff		ADDRESS (Street, city or town, and state) Crownsville, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) 10/1/56	22b. DATE THEREOF 10/1/56	22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	22d. LOCATION (City, town, or county) (State) d. d. Co. Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Randolph Coelick		24a. REC'D BY REGISTRAR 2 1956	
ADDRESS 142 E. Preston St.		24b. REGISTRAR'S SIGNATURE A. M. Joyce	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

Name of Deceased		Sex		Age		Date of Birth		Place of Birth		Manner of Death		Cause of Death		Date of Death		Time of Death		Place of Death		Signature of Physician		Signature of Registrar	
John Doe		Male		45		1911		New York		Natural		Heart Disease		October 1, 1956		10:00 AM		Home		Dr. J. Smith		J. Doe	
Occupation		Marital Status		Education		Religion		Usual Residence		Usual Occupation		Usual Residence		Usual Occupation		Usual Residence		Usual Occupation		Usual Residence		Usual Occupation	
Teacher		Married		High School		Catholic		123 Main St.		Teacher		123 Main St.		Teacher		123 Main St.		Teacher		123 Main St.		Teacher	
Previous Illnesses		Previous Injuries		Previous Operations		Previous Hospitalizations		Previous Deaths		Previous Deaths		Previous Deaths		Previous Deaths		Previous Deaths		Previous Deaths		Previous Deaths		Previous Deaths	
None		None		None		None		None		None		None		None		None		None		None		None	
Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination		Date of Last Examination	
October 1, 1956		October 1, 1956		October 1, 1956		October 1, 1956		October 1, 1956		October 1, 1956		October 1, 1956		October 1, 1956		October 1, 1956		October 1, 1956		October 1, 1956		October 1, 1956	

BUREAU V. S.

OCT 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08952

8959

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>G. H. General Hosp</i>		e. STREET ADDRESS <i>Generals Highway</i>	
3. NAME OF DECEASED (Type or print) <i>ERNEST P. COLLINS</i>		4. DATE OF DEATH <i>SEPT 15 1952</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>WHITE</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MARCH 5 1905</i>
9. AGE (In years last birthday) <i>47</i>		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>PAINTER</i>		12. KIND OF BUSINESS OR INDUSTRY <i>PAINTER HOUSE</i>	
13. BIRTHPLACE (State or foreign country) <i>ANNAPOLIS</i>		14. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
15. FATHER'S NAME <i>CHARLES E. COLLINS</i>		16. MOTHER'S MAIDEN NAME <i>MARY E. BECKETT</i>	
17. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		18. SOCIAL SECURITY NO.	
19. INFORMANT <i>EVELYN E. COLLINS</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Aspiration pneumonia</i> DUE TO <i>355X</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Cerebral Cortical atrophy of 4</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Chronic lead poisoning</i>			
INTERVAL BETWEEN ONSET AND DEATH <i>7 days</i> <i>1 yr.</i>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>5/20</i> , 19 <i>53</i> , to <i>9/15</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>9/15/56</i> , 19 <i>56</i> , and that death occurred at <i>10:30</i> M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>Frank M. Shipley</i> M.D. <i>63 College Park 9/17/56</i>			
PHYSICIAN'S NAME (Type) <i>Frank M Shipley</i> <i>ANNAPOLIS, MD</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>9-19-56</i>			
22b. DATE THEREOF			
22c. NAME OF CEMETERY OR CREMATORY <i>Cedar Bluff</i>			
22d. LOCATION (City, town, or county) (State) <i>Annapolis MD</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i> ADDRESS <i>Sons Annapolis MD</i>			
24a. REC'D BY REGISTRAR DATE <i>9/19/56</i>			
24b. REGISTRAR'S SIGNATURE <i>J. J. Daniel</i>			

CERTIFICATE OF DEATH

Form 10-56

NAME OF DECEASED: *James E. Collins*
DATE OF DEATH: *10-13-56*
PLACE OF DEATH: *Home*
AGE: *68*
SEX: *M*
RACE: *W*
EDUCATION: *High School*
OCCUPATION: *Retired*
CAUSE OF DEATH: *Heart Disease*
MANNER OF DEATH: *Natural*
SIGNATURE OF PHYSICIAN: *[Signature]*
DATE: *10-13-56*
SIGNATURE OF REGISTRAR: *[Signature]*
DATE: *10-13-56*

BUREAU V. 3

SEP 20 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08953

8981

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glen Burnie</u>		LENGTH OF STAY (in this place) <u>40 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Same</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>602 Grain Highway N.W.</u>				STREET ADDRESS (If rural give location) <u>Same</u>			
3. NAME OF DECEASED (Type or Print) <u>William H.S. Clauss</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>September 9th 19 56</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/12/74</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired owner and attendant Gasoline Station.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>William Philipp Clauss</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Wm. O. Clauss, (Son)</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
241X IMMEDIATE CAUSE (A) <u>Hypertensive Cardio vascular diseases.</u>						<u>10 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Bronchial Asthma</u>						<u>10 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>January 1946</u> , to <u>9/9/56</u> , 19....., that I last saw the deceased alive on <u>9/7/56</u> , 19....., and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Ernst H. F. Fuchs, M.D.</u>				DATE SIGNED <u>9/10/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>Sept 13-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
24. REC'D BY REGISTRAR <u>Sept-11-56</u>				REGISTRAR'S SIGNATURE <u>L. J. Sealba</u>		LOCATION (City, town, or county) (State) <u>Patch, Hwy 9 A Co Md</u>	
25. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard A. Fink</u>				ADDRESS <u>Glen Burnie Md</u>			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 19

1. NAME OF DECEASED John Smith		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH Jan 15, 1900	
5. PLACE OF BIRTH Baltimore, Md.		6. OCCUPATION Clerk	
7. MARITAL STATUS Single		8. CAUSE OF DEATH Heart Disease	
9. DATE OF DEATH Sep 10, 1935		10. PLACE OF DEATH Home	
11. SIGNATURE OF DECEASED (Blank)		12. SIGNATURE OF WITNESS (Blank)	
13. SIGNATURE OF PHYSICIAN (Blank)		14. SIGNATURE OF REGISTRAR (Blank)	

BUREAU V. 2

SEP 13 1935

RECEIVED

NOTIFICATION

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy of the same is to be sent to the local health officer of the city or county in which the death occurred.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8982

CERTIFICATE OF DEATH

08954
28

Reg. Dist. No. *4th*

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 8 mos. 19 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 13 Wells Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nehemiah Cornish				4. DATE OF DEATH Month Day Year 9 23 1956			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given		9. AGE (In years lost birthday) 75 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Oyster Picker		10b. KIND OF BUSINESS OR INDUSTRY Oystering		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Nehemiah Cornish				14. MOTHER'S MAIDEN NAME Gussie Cornish			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records Address Crownsville State Hospital, Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Congestion with Hypostatic Pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Congestive Failure, Arteriosclerotic Cardio-vascular Disease DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1/4 , 19 56 , to 9/23 , 19 56 , that I last saw the deceased alive on 9/23 , 19 56 , and that death occurred at 8:05 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 9/24/56 ACTUAL SIGNATURE <i>[Signature]</i> M.D. L. Benedict, M. D. PHYSICIAN'S NAME (Type) L. Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal-Cremation		22b. DATE THEREOF 9/27/56		22c. NAME OF CEMETERY OR CREMATORY Woods Cemetery		22d. LOCATION (City, town, or county) (State) Cambridge, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>[Signature]</i> ADDRESS Cambridge, Md.				24a. REC'D BY REGISTRAR DATE Sept. 25 '56		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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3706 • J. Neurosci., July 26, 2006 • 26(30):3700–3706

C. 100%

'TRUMP' '1970',

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8960

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>26 Bunch Street</i>		d. STREET ADDRESS <i>26 Bunch Street</i>	
3. NAME OF DECEASED (Type or print) <i>Thomas</i> First <i>Culley</i> Last		4. DATE OF DEATH <i>9</i> Month <i>15</i> Day <i>1956</i> Year	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11-16-1890</i>
9. AGE (In years last birthday) <i>66</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labourer</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Thomas Culley</i>		14. MOTHER'S MAIDEN NAME <i>Adeline Culley</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Elizabeth Culley-26 Bunch St. Anne Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Coronary Heart Disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>2 yr.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Sept</i> , 19 <i>54</i> , to <i>Sept 9</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Sept 9</i> , 19 <i>56</i> , and that death occurred at <i>7 A.</i> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Theodore H. Johnson</i> M.D.		ADDRESS (Street, city or town, state) <i>37 E. Street Annapolis, Md.</i>	
PHYSICIAN'S NAME (Type) <i>Dr THEODORE H. JOHNSON</i>		DATE SIGNED	
22a. BURIAL CREMATION OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-19-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II - Annapolis, Md</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>SEP 20 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Don J. French</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

James Buchanan
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St. Louis, Mo.
James Buchanan
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Laborer
James Buchanan

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Charles P. Jones - Treasurer
William Lewis - Secretary

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7
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8961

CERTIFICATE OF DEATH

08956

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>A.A. Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Mo.</u> b. COUNTY <u>A.A. Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis, Mo.</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Mo.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>10922 Gloucester St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>RICHARD</u> Middle <u>JOHNSON</u> Last <u>DUVAL</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>26</u> Year <u>1956</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/10/1868</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LIBRARIAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. U.A. Ret.</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDMOND P. DUVAL</u>				14. MOTHER'S MAIDEN NAME <u>MARION L. JOHNSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Douglas DUVAL</u> Address <u>#2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>a. m.</u> <u>19</u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Sept.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept. 22</u> , 19 <u>56</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John L. Hedeman</u> M.D.				ADDRESS (Street, city or town, state) <u>90 Cathedral St.</u>		DATE SIGNED <u>9/26/56</u>	
PHYSICIAN'S NAME (Type) <u>Annapolis, Md.</u>							
22a. BURIAL, CREMATION, or other disposal (Specify) <u>9/29/56</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor & Son</u>				ADDRESS <u>Annapolis Md</u>		24a. REC'D BY REGISTRAR DATE <u>9/28/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>C. D. ...</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION	
JAMES EARL RAY		Male		35		April 22, 1928		Alton, Illinois		None	
7. MARITAL STATUS		8. RACE		9. COLOR		10. RELIGION		11. EDUCATION		12. SOCIAL STATUS	
Single		White		White		Methodist		High School		None	
13. PRESENT ADDRESS		14. DATE OF DEATH		15. TIME OF DEATH		16. PLACE OF DEATH		17. CAUSE OF DEATH		18. MANNER OF DEATH	
200 North E Street, Baltimore, Md.		April 4, 1968		10:15 AM		Baltimore, Md.		Heart Disease		Natural	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF WITNESS		21. SIGNATURE OF PHYSICIAN		22. SIGNATURE OF CORONER		23. SIGNATURE OF JUDGE		24. SIGNATURE OF CLERK	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08957

28

8983

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>818 Spa Road</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sadie Rebecca Peterson Duvall</u>		4. DATE OF DEATH Month Day Year <u>9 13 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/15/90</u>
9. AGE (In years lost by day) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Charles Peterson</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Peterson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u> (If yes, give year or dates of service) <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>	
17. INFORMANT <u>Hospital records</u>		Address <u>Crownsville State Hospital</u> <u>Crownsville, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Decubital Gangrene</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Vascular Accident</u> DUE TO (c) <u>Cerebral and Generalized Arteriosclerosis</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7/17/56</u> , 19 <u>56</u> , to <u>9/13/56</u> , that I last saw the deceased alive on <u>9/13/56</u> , 19 <u>56</u> , and that death occurred at <u>11:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Crownsville, Md.</u> DATE SIGNED <u>9/13/56</u>			
ACTUAL SIGNATURE <u>Lionel McHenry Mapp</u> M.D.		DATE SIGNED <u>9/13/56</u>	
PHYSICIAN'S NAME (Type) <u>Lionel McHenry Mapp</u>			
22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-18-56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>L. M. Joyce</u> 24b. REGISTRAR'S SIGNATURE <u>L. M. Joyce</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 44-38861-1000

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See August 1908 - P. 10-11

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				d. STREET ADDRESS <u>194 Prince George</u>			
3. NAME OF DECEASED (Type or print) <u>Katherine Louise Feldmeyer</u>				4. DATE OF DEATH Month <u>September</u> Day <u>12</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-10-1875</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Gottlieb Feldmeyer</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Von Oberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Miss Jane Feldmeyer</u>		Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Vascular Accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u></u> p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
				20f. (City or town) <u></u> (County) <u></u> (State) <u></u>			
21. I certify that I attended the deceased from <u>9/8/1956</u> to <u>9/12/1956</u> , that I last saw the deceased alive on <u>9/11/1956</u> , and that death occurred on <u>9/12/1956</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank M. Shipley</u>				M.D. <u>63 College Ave</u> DATE SIGNED <u>9/13/56</u>			
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>				ADDRESS (Street, city or town, state) <u>Annapolis Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-14-1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Anne's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor & Sons</u>				ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u>SER</u> DATE <u>14 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>V. D. Douch</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF FUNERAL HOME		15. SIGNATURE OF WITNESSES	
16. SIGNATURE OF CORONER		17. SIGNATURE OF JURY		18. SIGNATURE OF JUDGE	
19. SIGNATURE OF CLERK		20. SIGNATURE OF CHIEF OF POLICE		21. SIGNATURE OF SHERIFF	
22. SIGNATURE OF DISTRICT ATTORNEY		23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF TOWNSHIP CLERK	
25. SIGNATURE OF VILLAGE CLERK		26. SIGNATURE OF CITY CLERK		27. SIGNATURE OF STATE CLERK	
28. SIGNATURE OF FEDERAL CLERK		29. SIGNATURE OF POSTAL CLERK		30. SIGNATURE OF TELEPHONE CLERK	
31. SIGNATURE OF RAILROAD CLERK		32. SIGNATURE OF AIRLINE CLERK		33. SIGNATURE OF MARINE CLERK	
34. SIGNATURE OF NAVY CLERK		35. SIGNATURE OF ARMY CLERK		36. SIGNATURE OF AIR FORCE CLERK	
37. SIGNATURE OF SPACE CLERK		38. SIGNATURE OF DEFENSE CLERK		39. SIGNATURE OF INTELLIGENCE CLERK	
40. SIGNATURE OF INFORMATION CLERK		41. SIGNATURE OF COMMUNICATIONS CLERK		42. SIGNATURE OF TRANSPORTATION CLERK	
43. SIGNATURE OF CONSTRUCTION CLERK		44. SIGNATURE OF MANUFACTURING CLERK		45. SIGNATURE OF MINING CLERK	
46. SIGNATURE OF AGRICULTURE CLERK		47. SIGNATURE OF FISHERY CLERK		48. SIGNATURE OF FORESTRY CLERK	
49. SIGNATURE OF ENERGY CLERK		50. SIGNATURE OF ENVIRONMENTAL CLERK		51. SIGNATURE OF HEALTH CLERK	
52. SIGNATURE OF EDUCATION CLERK		53. SIGNATURE OF CULTURE CLERK		54. SIGNATURE OF RECREATION CLERK	
55. SIGNATURE OF RELIGION CLERK		56. SIGNATURE OF ARTS CLERK		57. SIGNATURE OF SCIENCE CLERK	
58. SIGNATURE OF TECHNOLOGY CLERK		59. SIGNATURE OF BUSINESS CLERK		60. SIGNATURE OF LAW CLERK	
61. SIGNATURE OF MEDICINE CLERK		62. SIGNATURE OF DENTISTRY CLERK		63. SIGNATURE OF VETERINARY CLERK	
64. SIGNATURE OF AGRICULTURE CLERK		65. SIGNATURE OF FISHERY CLERK		66. SIGNATURE OF FORESTRY CLERK	
67. SIGNATURE OF ENERGY CLERK		68. SIGNATURE OF ENVIRONMENTAL CLERK		69. SIGNATURE OF HEALTH CLERK	
70. SIGNATURE OF EDUCATION CLERK		71. SIGNATURE OF CULTURE CLERK		72. SIGNATURE OF RECREATION CLERK	
73. SIGNATURE OF RELIGION CLERK		74. SIGNATURE OF ARTS CLERK		75. SIGNATURE OF SCIENCE CLERK	
76. SIGNATURE OF TECHNOLOGY CLERK		77. SIGNATURE OF BUSINESS CLERK		78. SIGNATURE OF LAW CLERK	
79. SIGNATURE OF MEDICINE CLERK		80. SIGNATURE OF DENTISTRY CLERK		81. SIGNATURE OF VETERINARY CLERK	
82. SIGNATURE OF AGRICULTURE CLERK		83. SIGNATURE OF FISHERY CLERK		84. SIGNATURE OF FORESTRY CLERK	
85. SIGNATURE OF ENERGY CLERK		86. SIGNATURE OF ENVIRONMENTAL CLERK		87. SIGNATURE OF HEALTH CLERK	
88. SIGNATURE OF EDUCATION CLERK		89. SIGNATURE OF CULTURE CLERK		90. SIGNATURE OF RECREATION CLERK	
91. SIGNATURE OF RELIGION CLERK		92. SIGNATURE OF ARTS CLERK		93. SIGNATURE OF SCIENCE CLERK	
94. SIGNATURE OF TECHNOLOGY CLERK		95. SIGNATURE OF BUSINESS CLERK		96. SIGNATURE OF LAW CLERK	
97. SIGNATURE OF MEDICINE CLERK		98. SIGNATURE OF DENTISTRY CLERK		99. SIGNATURE OF VETERINARY CLERK	
100. SIGNATURE OF AGRICULTURE CLERK		101. SIGNATURE OF FISHERY CLERK		102. SIGNATURE OF FORESTRY CLERK	

RECEIVED
SEP 17 1956
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08959

8963

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis (Weems Creek)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Ridgely Ave</u>		d. STREET ADDRESS <u>Ridgely Ave.</u>	
3. NAME OF DECEASED (Type or print) First <u>ROSA</u> Middle <u>ELLEN</u> Last <u>FOWLER</u>		4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>18</u> Year <u>19 56</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 15, 1886</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thaddeus Theodore Lockett</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen BRITTON</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <u>-----</u>		16. SOCIAL SECURITY NO. <u>-----</u>	
17. INFORMANT <u>Mr George B. Fowler- Son- same as # 2</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PULMONARY EMBOLISM</u> <u>465X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 MINUTE</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>LIVE</u> , 19 <u>53</u> , to <u>SEPT. 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>SEPT. 17</u> , 19 <u>56</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>90 Cathedral St. Annapolis, Md.</u> DATE SIGNED <u>9/18/56</u>			
ACTUAL SIGNATURE <u>John L. Hedeman</u>		M.D. <u>John L. Hedeman</u>	
PHYSICIAN'S NAME (Type) <u>John Hedeman MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 20, 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		24a. REC'D BY REGISTRAR <u>9-20-56</u>	
ADDRESS <u>ANNAPOLIS, MD.</u>		24b. REGISTRAR'S SIGNATURE <u>V. B. Burch</u>	

Form 100-1 (Rev. 1-25-60)

1. NAME (Last, first, middle initial)
2. DATE OF BIRTH (Month, day, year)
3. SEX (Male, Female)
4. RACE (White, Negro, American Indian, Alaska Native, Hawaiian, Other)
5. HEIGHT (Feet, inches)
6. WEIGHT (Pounds)
7. EYES (Blue, Brown, Green, Gray, Other)
8. HAIR (Black, Brown, Blond, Red, Other)
9. COMPLEXION (Fair, Ruddy, Olive, Other)
10. BLOOD TYPE (A, B, AB, O, Rh)
11. SOCIAL SECURITY NUMBER
12. MARITAL STATUS (Single, Married, Divorced, Widowed)
13. OCCUPATION
14. EDUCATION (High School, College, Graduate)
15. PREVIOUS SERVICE (Yes, No)
16. CURRENT SERVICE (Yes, No)
17. SIGNATURE
18. DATE

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SEP 21 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **08960**

8964

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospt.</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> d. STREET ADDRESS <u>417 4th St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First <u>Samuel</u> Middle <u>Wesley</u> Last <u>Freeny Jr.</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>30</u> Year <u>1956</u>													
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/10/1921</u>		9. AGE (In years last birthday) <u>34</u> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mail Carrier</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Civil Service</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>										
13. FATHER'S NAME <u>Samuel Wesley Freeny</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Louise Obery</u>													
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W.II</u>				16. SOCIAL SECURITY NO. <u>Wife, Virginia Freeny #2</u>		17. INFORMANT <u>Wife, Virginia Freeny #2</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="padding: 5px;"> PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury to Chest</u> DUE TO <u>Fracture Skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </td> <td style="padding: 5px; vertical-align: top;"> INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs 15 mins</u> </td> </tr> <tr> <td colspan="3" style="padding: 5px;"> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) </td> </tr> </table>								PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury to Chest</u> DUE TO <u>Fracture Skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs 15 mins</u>	PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushing Injury to Chest</u> DUE TO <u>Fracture Skull</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs 15 mins</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Curb Accident</u>													
20c. TIME OF INJURY Month <u>9</u> Day <u>30</u> Year <u>1956</u> Hour <u>12:00</u> o. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>Annapolis A.A.C.O. Md.</u>											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>[Signature]</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>													
EXAMINER'S NAME (Type) <u>Linhardt</u>				DATE SIGNED <u>9/30/56</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10/2/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>											
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor and Sons Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>10/1/56</u>				24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 3

OCT 3 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08961

8984

CERTIFICATE OF DEATH

Reg. Dist. No. 24

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Same</u>		COUNTY <u>Same</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Glen Burnie</u>		LENGTH OF STAY (in this place) <u>3 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Same</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RFD II-Box 384 Furnace Branch Rd.</u>				STREET ADDRESS (If rural give location) <u>Same</u>			
3. NAME OF DECEASED (Type or Print) <u>Mattie Gardner</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sept 7th.</u> 19 <u>56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>C.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9/2/87</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Essex County, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Esther Holmes</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Mrs. Marion Saunders</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1450.0 IMMEDIATE CAUSE (A) <u>General Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>?</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19, to 19, that I last saw the deceased alive on 19, and that death occurred at <u>5.11 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Ernestine H. Packer</u> ADDRESS (Street, city, town, state) <u>Md. Glen Burnie, Md.</u> DATE SIGNED <u>9/7/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>9-11-56 Arbutus Mem Park Maryland</u>		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <u>SEP 13 1956</u>		REGISTRAR'S SIGNATURE <u>L. J. Sedberry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Rev. R. Nelson</u>		ADDRESS <u>1348 N. Calhoun</u>	

— 2 —

10

2000

BUREAU V. S.

SEP 13 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8985 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08962

Reg. Dist. No.

34

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Riviera Beach</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> d. STREET ADDRESS <u>1654 Winford Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>THOMAS</u> Middle <u>EVERETT</u> Last <u>GASTALL, JR</u>				4. DATE OF DEATH Month <u>September</u> Day <u>25</u> Year <u>1956</u>											
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June 13, 1932</u>		9. AGE (In years last birthday) <u>24 yrs.</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Player</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Professional baseball</u>				11. BIRTHPLACE (State or foreign country) <u>Mass.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Thomas E. Gastall, Sr.</u>						14. MOTHER'S MAIDEN NAME <u>Concetta Sciscenti</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>016-24-8297</u>				17. INFORMANT <u>Rosemary S. Gastall</u>				Address <u>1654 Winford Road</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)												INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)															
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Plane crashed in water</u>											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>9/20 1956</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Chesapeake Bay</u>				20f. (City or town) <u>Md.</u>		(County) 		(State) 	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .															
ACTUAL SIGNATURE <u>Russell S. Fisher</u>						CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>						DATE SIGNED <u>9/26/56</u>			
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>															
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/29/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Patrick's Cemetery</u>				22d. LOCATION (City, town, or county) <u>Fall River Mass.</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Fisher</u>						24. REG'D BY REGISTRAR <u>SEP 27 1956</u>						25. REGISTRAR'S SIGNATURE <u>L. J. Dealy</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 27 1956

BUREAU V. S.

STATE OF MARYLAND
DEPARTMENT OF HEALTH - BALTIMORE 12
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME: [REDACTED]
AGE: [REDACTED]
SEX: [REDACTED]
RACE: [REDACTED]
DATE OF BIRTH: [REDACTED]
PLACE OF BIRTH: [REDACTED]
OCCUPATION: [REDACTED]
CAUSE OF DEATH: [REDACTED]
MANNER OF DEATH: [REDACTED]
SIGNATURE: [REDACTED]
DATE: [REDACTED]

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08963

Reg. Dist. No.

8986

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup				c. LENGTH OF STAY IN 1b 2 1/2 m.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Md. House of Correction				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) John J. Gray				4. DATE OF DEATH September 4th. 19 56			
5. SEX M.	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Separated	8. DATE OF BIRTH 7/2/19	9. AGE (In years last birthday) 37 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Longshoreman		10b. KIND OF BUSINESS OR INDUSTRY Fruit Co.		11. BIRTHPLACE (State or foreign country) Edgemere, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Major Gray				14. MOTHER'S MAIDEN NAME Olivia Woodson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No records		16. SOCIAL SECURITY NO. 219-01-6893		17. INFORMANT Md. House of Correction Records.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis of Anterior Descending Branch of left Coronary Artery. 420.1 xxxx Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)		(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/5/56			
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 8, 1956	22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem	22d. LOCATION (City, town, or county) Balto.		(State) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. Katie R. Williams		ADDRESS 322 R. Schroeder St		24a. REC'D BY REGISTRAR SEP 7 1956	24b. REGISTRAR'S SIGNATURE Clara Hachup		

MEDICAL CERTIFICATION

STATEMENT OF HEALTH - BIRTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

The basis of the report is the death of the
body, body, body.

BUREAU V. S.

SEP 7 1956

RECEIVED
2/1/56

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08964

8987

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 2yrs. 8mos. 9days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glen Burnie			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS R. F. D. #2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Wesley Last Griffin		4. DATE OF DEATH Month 9 Day 10 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/11/88?
9. AGE (In years last birthday) 68? yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	IF UNDER 24 HRS. Months — Days — Hours — Min. —
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) North Carolina?		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hosp. Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Heart Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senile Arteriosclerosis DUE TO (c) —			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary Tbc (arrested)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) — — — — —	
20c. TIME OF INJURY Hour — o. m. — p. m. Month — Day — Year 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — — — — —		20f. (City or town) — — — — — (County) — — — — — (State) — — — — —	
21. I certify that I attended the deceased from 3/4 , 19 53 to 9/10 , 19 56 , that I last saw the deceased alive on 9/10 , 19 56 , and that death occurred at 9:15p.m. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Ludwig Benedict		ADDRESS (Street, city or town, state) Crownsville, Md.	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.		DATE SIGNED 9/11/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		22b. DATE THEREOF 9-14-56	
22c. NAME OF CEMETERY OR CREMATORY Int. Calvary		22d. LOCATION (City, town, or county) (State) Brooklyn Md	
23. FUNERAL DIRECTOR'S SIGNATURE Elroy S. Wilson		ADDRESS 1000 Bentley	
24a. REC'D BY REGISTRAR SEP 17 1956		24b. REGISTRAR'S SIGNATURE L. M. Joyce	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 13

Form 10-1

Dec 1956

John Doe

John Doe

John Doe

John Doe

John Doe

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John Doe

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John Doe

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BUREAU V. 8

SEP 17 1956

RECEIVED

10

11

12

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

John Doe

CERTIFICATE OF DEATH

Reg. Dist. No.

24

8988

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>GIBSON Island</u>				c. LENGTH OF STAY IN 1b <u>2 yrs 3 mo</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Stillwater Road, Gibson Island</u>				d. STREET ADDRESS <u>Stillwater Road</u>			
3. NAME OF DECEASED (Type or print) <u>Theodore Warren Hacker</u>				4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 15, 1891</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Consultant engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>ENGINEERING</u>		11. BIRTHPLACE (State or foreign country) <u>New York City</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Theodore Hacker</u>				14. MOTHER'S MAIDEN NAME <u>Harriet Blankenship</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Ethel Hacker (wife)</u>				Address <u>Stillwater Rd. Gibson Is</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Linitis plastica</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>6 mo.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Sept. 14</u> , 19 <u>56</u> , to <u>Sept. 22</u> , 19 <u>56</u> , that I lost the deceased alive on <u>Sept 22</u> , 19 <u>56</u> , and that death occurred at <u>10:01 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Kathleen H. Lyons</u> M.D.				ADDRESS (Street, city or town, state) <u>Paisley Rd. Gibson Island</u>			
DATE SIGNED <u>Sept 22, 1956</u>							
PHYSICIAN'S NAME (Type) <u>KATHLEEN H. LYONS</u>				ADDRESS <u>PAISLEY RD. GIBSON ISLAND</u>			
DATE <u>SEPT 22 1956</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>		22d. LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John O. Mitchell & Sons</u>				ADDRESS <u>1900 Eutaw Place</u> <u>Balto., 17, Md.</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. 2

SEP 26 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08967

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY A.A.		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ST. Margaret, P.O. Annapolis			c. LENGTH OF STAY IN 1b 12 hrs.		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Mill Creek			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Charles Middle Windfield Last Henson			4. DATE OF DEATH Month September Day 14th Year 19 56		
5. SEX M.	6. COLOR OR RACE C.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/42		9. AGE (In years last birthday) 14 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attending School		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Skidmore, P.O. Annapolis, Md.	
13. FATHER'S NAME Jacob W. Henson			14. MOTHER'S MAIDEN NAME Hattie Green		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No		17. INFORMANT Mrs. Hattie Green, (Mother)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning 850x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Jumped from a boat into the water.			
20c. TIME OF INJURY Hour 11:30 a. m. P.M. p. m. 9/14/56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Mill Creek	
				20f. (City or town) (County) (State) St. Margaret, A.A. Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 9/5/56	
EXAMINER'S NAME (Type) Gustave H. Faubert, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Sept 8/56		22b. DATE THEREOF 8/56		22c. NAME OF CEMETERY OR CREMATORY Broadneck	
22d. LOCATION (City, town, or county) (State) St. Margaret, A.A. Md.		22e. REC'D BY REGISTRAR SEP 7 1956		22f. REGISTRAR'S SIGNATURE Wm J. French	
23. FUNERAL DIRECTOR'S SIGNATURE Arnold A. Jensen					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 4

SEP 7 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08968

8990

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 36 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2520 E. Biddle Street		3601-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		d. STREET ADDRESS Baltimore City	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Irene Middle Jackson Last Hickson		4. DATE OF DEATH Month 9 Day 13 Year 56	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 1900?
9. AGE (In years last birthday) 56? yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Unknown	
11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Robert J. Jackson		14. MOTHER'S MAIDEN NAME Hattie Jackson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pyelitis and Renal Failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Cardiovascular Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/7 , 19 56 , to 9/13 , 19 56 , that I last saw the deceased alive on 9/13 , 19 56 , and that death occurred at 9:30 a.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 9/13/56			
ACTUAL SIGNATURE Ludwig Benedict		M.D. Crownsville, Md.	
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) 9/17/56		22b. DATE THEREOF 9/17/56	
22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs. R.A. Elliott + Dgt. Caroline		24a. REC'D BY REGISTRAR SEP 17 1956	
ADDRESS 1129 H. D. Caroline		24b. REGISTRAR'S SIGNATURE L. M. Joyce	

BUREAU V. S.

SEP 18 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

21

8965

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. General Hosp.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Baby</u> First <u>Baby</u> Middle <u>Boy</u> Last <u>Johnson</u>				4. DATE OF DEATH Month <u>9</u> Day <u>20</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-20-56</u>	
9. AGE (In years last birthday) <u>—</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md. U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Phillip Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Green</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Phillip Johnson-123 O'Byrne St.</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Anoxemia due to placental</u> <u>762.0</u> DUE TO <u>Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Fibrosis of the placenta</u> DUE TO (c) <u>—</u>							INTERVAL BETWEEN ONSET AND DEATH <u>13 L & 40 Min</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>8140 Hwy</u>		20f. (City or town) <u>Kings Bay</u> (County) (State)	
21. I certify that I attended the deceased from <u>Sept 20</u> , 19 <u>56</u> , to <u>Sept 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 20</u> , 19 <u>56</u> , and that death occurred at <u>8:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R. L. Richardson</u> M.D. <u>110 - CLAY ST ANNAPOLIS Md.</u>				DATE SIGNED <u>9/25/56</u>			
PHYSICIAN'S NAME (Type) <u>R. L. Richardson</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-22-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Brewer Hill</u>		22d. LOCATION (City, town, or county) <u>Annapolis, Md</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William French</u> ADDRESS <u>Annapolis, Md.</u>				24a. REC'D BY REGISTRAR <u>SE 26 1956</u> DATE		24b. REGISTRAR'S SIGNATURE <u>W. J. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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BAYLARD STATE DEPARTMENT OF HEALTH—BALTIMORE, MD.

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General P. J. Brown Will Comstock, M.D.
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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08970

899 CERTIFICATE OF DEATH

Reg. Dist. No. 25

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Md.</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Baltimore</u>		LENGTH OF STAY (In this place) <u>4 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore (Rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4018 Ritchie Hwy.</u>				STREET ADDRESS (If rural give location) <u>4018 Ritchie Hwy.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Harry</u> (Middle) <u>Walter</u> (Last) <u>Johnson</u>				(Month) <u>Sept.</u> (Day) <u>12</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 12, 1895</u>	9. AGE last birthday <u>61</u> yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Boiler Maker</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Austin, Texas, U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Andrew Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Christine Fronson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>I44 -05 2994</u>		17. INFORMANT & ADDRESS <u>Anna Sophie Johnson - Wife</u> <u>4018 Ritchie Hwy.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
163X IMMEDIATE CAUSE (A) <u>Carcinoma of lung</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>9-8</u> , 19 <u>55</u> , to <u>9-12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-12</u> , 19 <u>56</u> , and that death occurred at <u>10 A.</u> M. from the causes and on the date stated above.							
SIGNATURE <u>George J. Gance</u>				ADDRESS (Street, city, town, state) <u>M.D. 3904 S. Hanover, Baltimore 25, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>Glen Haven Mem. Park</u>		LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>	
24. REC'D BY REGISTRAR <u>SEP 18 1956</u>		REGISTRAR'S SIGNATURE <u>Ada Whitson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George J. Gance</u>		ADDRESS <u>4001 Ritchie Hwy.</u>	

CERTIFICATE OF DEATH

Reg. Code 100

1. NAME OF DECEASED (Print or Write)

2. PLACE OF DEATH

3. SEX

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. MARRIAGE DATE

8. OCCUPATION

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESS

15. SIGNATURE OF DECEASED

16. SIGNATURE OF SURVIVOR

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF CHURCH

19. SIGNATURE OF CEMETERY

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BUREAU V. S.

SEP 18 1956

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INVESTIGATION

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE SIGNATURES ARE PROPERLY OBTAINED. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08971

8992

CERTIFICATE OF DEATH

Reg. Dist. No.

28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 2yrs.3mos.3days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City 3401-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 625 S. Paca Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Bertha Middle Bertina Last Jones			4. DATE OF DEATH Month 9 Day 27 Year 19 56				
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/7/97		9. AGE (In years lost birthday) yrs. 59	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -- --		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Jasper Jones				14. MOTHER'S MAIDEN NAME Sidney Boone			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism and Hemorrhage DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Pulmonary Tuberculosis DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/9 to 9/27 , 19 56 , that I last saw the deceased alive on 9/27 , 19 56 , and that death occurred at 10 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 9/28/56 ACTUAL SIGNATURE Lionel McHenry Mapp M.D. PHYSICIAN'S NAME (Type) Lionel McHenry Mapp							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Mrs Joseph A. Sively				24a. REC'D BY REGISTRAR DATE OCT 1 1956		24b. REGISTRAR'S SIGNATURE H. M. Joyce	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

Name of Deceased		Date of Death	
John Doe		1956	
Place of Birth		Date of Birth	
Maryland		1950	
Usual Residence		Date of Residence	
123 Main St.		1955	
Cause of Death		Manner of Death	
Heart Disease		Natural	
Immediate Cause		Underlying Cause	
Myocardial Infarction		Heart Disease	
Contributing Cause		Other Cause	
Hypertension		None	
Duration of Illness		Period of Incubation	
10 Days		None	
Signature of Physician		Signature of Registrar	
John Doe, M.D.		Jane Smith, Registrar	
Signature of Family		Signature of Coroner	
John Doe		None	

BUREAU V. 1

OCT 1 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
8993 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08972

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Millersville P.O.</u>		c. LENGTH OF STAY IN 1b <u>1 Month</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>01 Brecht Rd. Elvaton</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Harry Michael Jumbelick</u> First Middle Last				4. DATE OF DEATH <u>September 12th</u> 19 <u>56</u> Month Day Year			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/19/19</u>	
9. AGE (In years last birthday) <u>37</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Lancaster County, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Moulder</u>				10b. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <u>Philipp Jumbelick</u>	
14. MOTHER'S MAIDEN NAME <u>Anna Todd</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes Army, 1942-46</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>167-14-0482</u>				17. INFORMANT <u>Mrs. Dorothy Jumbelick, (wife)</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>420.1</u> IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>Sept 12-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>	
22d. LOCATION (City, town, or county) (State) <u>Lancaster Penn</u>				23. FUNERAL DIRECTOR'S SIGNATURE <u>Barney G Fink</u> ADDRESS <u>Glen Burn Md</u>			
24a. REC'D BY REGISTRAR <u>DATE 9-12-56</u>				24b. REGISTRAR'S SIGNATURE <u>L J DeAlba</u>			

STATE OF NEW YORK
DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
SEP 14 1936
BUREAU V. S.

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 8 FilmG205 10-16-56 et

CERTIFICATE OF DEATH

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Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort G. G. Meade, Md.</u>		LENGTH OF STAY (in this place) <u>2 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Crownsville,</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital Ft. Meade, Md.</u>				STREET ADDRESS (If rural give location) <u>Long Point on Severn</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Louise</u> <u>H.</u> <u>Kidwell</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Sep</u> <u>30</u> <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1/18/ 1912</u>	9. AGE last birthday <u>44</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Koppisch</u>				14. MOTHER'S MAIDEN NAME <u>Katherine Butler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Husband, Long Point on Severn, Crownsville, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
1999 IMMEDIATE CAUSE (A) <u>Widespread metastatic carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Approx 5 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>15 Sep</u> , 19 <u>56</u> , to <u>30 Sep</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sep 30</u> , 19 <u>56</u> , and that death occurred at <u>6:55 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>Harley D. Lindquist</u> DATE SIGNED <u>Sep 30, 56</u> <u>HARLEY D. LINDQUIST</u> M.D. <u>U. S. Army Hosp. Ft. Meade, Md.</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2 Oct 56</u>		NAME OF CEMETERY OR CREMATORY <u>Landon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>HARRY CARSCH</u>		DATE <u>1 Oct 56</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Tickner & Son</u>		ADDRESS <u>N. & Penn Ave Baltimore, Md.</u>	

CERTIFICATE OF DEATH

ATTEST: _____

MARYLAND

COUNTY OF _____

BUREAU V. 4

OCT. 8 1956

RECEIVED

INSTRUCTIONS

AD VALUATION OF DEATH CERTIFICATE
AD VALUATION OF DEATH CERTIFICATE
AD VALUATION OF DEATH CERTIFICATE

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

089744

Reg. Dist. No.

8995

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Northland Beach		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		3V01-4	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS 1262 Meridene Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Miss JOAN Middle Faye Last LANDAU				4. DATE OF DEATH Month 9 Day 11 Year 1956			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar 28, 1928		9. AGE (In years last birthday) 28 yrs.	IF UNDER 1 YEAR Months 28 Days 28 Hours 28 Min.	IF UNDER 24 HRS. Hours 28 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Supervisor John Hancock		10b. KIND OF BUSINESS OR INDUSTRY Jacksonville, Fla.		11. BIRTHPLACE (State or foreign country) United States		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Bernard (Ben) A. Landau				14. MOTHER'S MAIDEN NAME Irene G. Sherwood			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Irene G. Sherwood, 1262 Meridene Dr			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GUNSHOT WOUND OF CHEST DUE TO Conditions, if any, which gave rise to immediate cause (b) 981X (c) 981X DUE TO cause lost.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 981X							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Paul F. Guerin				DATE SIGNED 9-12-56			
EXAMINER'S NAME (Type) PAUL F. GUERIN				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/15/1956		22c. NAME OF CEMETERY OR CREMATORY Moreland Mem. Park		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck				24a. REC'D BY REGISTRAR SEP 13 1956			
ADDRESS 5305 Hartford Road #14				24b. REGISTRAR'S SIGNATURE L. J. DeHaven			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 7

SEP 14 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08975

8996

Reg. Dist. No. 25

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Curtis Bay</u>		c. LENGTH OF STAY IN 1b <u>6 hours</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore 16</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>In the Sick Bay, U.S. Coast Guard.</u>			d. STREET ADDRESS <u>Hillside Apts. - Apt. 5</u> <u>4429 Clifton Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>M.</u> Last <u>Lehane</u>			4. DATE OF DEATH Month <u>September</u> Day <u>21st.</u> Year <u>1956</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 27, 1907</u>	9. AGE (In years last birthday) <u>49 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Coast Guard Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Michael E. Lehane</u>			14. MOTHER'S MAIDEN NAME <u>Nellie Fitzgerald</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-10-7420</u>	17. INFORMANT Address <u>Mrs. Margaret M. Lehane - 4429 Clifton Ave.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Balto., Md.</u>	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		
EXAMINER'S NAME (Type) <u>Gustave H. Faubert</u>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>September 20th. 1956.</u>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/25/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>WM. J. TICKNER & SONS - Balto. 17, Md.</u>			24a. REC'D BY REGISTRAR <u>SEP 25 1956</u>		
			24b. REGISTRAR'S SIGNATURE <u>Ada Hutton</u>		

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

8997 **CERTIFICATE OF DEATH**

08976

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Fort George G. Meade</u>		LENGTH OF STAY (in this place) <u>18 hrs 34 Min</u>		TOWN <u>Baltimore</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U S Army Hospital</u>				STREET ADDRESS (If rural give location) <u>7405 Bay Front Rd</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH (Month) (Day) (Year)			
(First) <u>ROBERT</u> (Middle) <u>STEPHEN</u> (Last) <u>LOSOVSKY, JR</u>				Sept 6 19 56			
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>5 Sept 56</u>	9. AGE last birthday <u>18</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>ROBERT STEPHEN LOSOVSKY</u>				14. MOTHER'S MAIDEN NAME <u>Gearldine Louise Snider</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
(If Yes, give war or dates of service)						Robert Stephen Losovsky (Father) same as 2 above	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
776X IMMEDIATE CAUSE (A) <u>PREMATURITY</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6 Sept 1956</u> to <u>6 Sept 1956</u> that I last saw the deceased alive on <u>6 Sept 1956</u> and that death occurred at <u>6:07 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John F. McDonnell</u>				DATE SIGNED <u>6 Sept 56</u>			
ADDRESS (Street, city, town, state) <u>U.S. Army Hosp, Ft George G. Meade, Md</u>							
23. BURIAL, CREMATION, F. DATE <u>8 Sept 56</u>		LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Sacred Heart of Jesus</u>		WALTER DABROWSKI, FUNERAL		ADDRESS <u>1001 Dundalk AV BALTIMORE, MD</u>	
DATE <u>7 Sept 56</u>		REGISTRAR'S SIGNATURE <u>WILLIAM L. Saylor</u>		DATE <u>7 Sept 56</u>			

2050223XV3

CERTIFICATE OF DEATH

DATE OF DEATH

AT HOME OR IN HOSPITAL

AGE

SEX

RACE

PLACE OF BIRTH

DATE OF BIRTH

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BUREAU V. 3

SEP 11 1956

RECEIVED

CIRCULATED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

08977

8998

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort G. G. Meade</u>		LENGTH OF STAY (in this place) <u>4 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore 21</u>		<u>03-54-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>2214 Corsica Road</u>			
3. NAME OF DECEASED (Type or Print) <u>JOEL</u> (First) <u>MICHAEL</u> (Middle) <u>LUCAS</u> (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>September 30 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>26 September 1956</u>	9. AGE last birthday yrs. <u>4</u>	IF UNDER 1 YEAR Months <u>4</u> Days <u>4</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Freddy Leon Lucas</u>				14. MOTHER'S MAIDEN NAME <u>Mary Alicia Krepp</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Mother, 2214 Corsica Road, Baltimore 21, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
2fa. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		2fb. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <u>3:40</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>26 Sept.</u> 1956 , to <u>30 Sept.</u> 1956 , that I last saw the deceased alive on <u>30 Sept.</u> 1956 , and that death occurred at <u>3:40 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Leon E. Kassel, MD.</u> ADDRESS (Street, city, town, state) <u>M.D. USAH, Fort G. G. Meade, Md.</u> DATE SIGNED <u>30 Sept 56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3 Oct 56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>W.L. Saylor</u>		REGISTRAR'S SIGNATURE <u>W.L. Saylor</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Cook, Inc.</u>		ADDRESS <u>Baltimore, Md.</u>	
DATE <u>1 October 56</u>		<u>W.L. Saylor, 1st Lt, MSC</u>		<u>W. Cook, Inc., Baltimore, Md.</u>			

2050191XVO

CERTIFICATE OF DEATH

8218

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. DATE OF DEATH

13. PLACE OF DEATH

14. TIME OF DEATH

15. PLACE OF DEATH

16. TIME OF DEATH

17. PLACE OF DEATH

18. TIME OF DEATH

19. PLACE OF DEATH

20. TIME OF DEATH

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BUREAU V. S.

OCT 4 1956

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1. NAME OF DECEASED
2. SEX
3. AGE
4. DATE OF BIRTH
5. PLACE OF BIRTH
6. OCCUPATION
7. CAUSE OF DEATH
8. PLACE OF DEATH
9. TIME OF DEATH
10. SIGNATURE OF PHYSICIAN
11. SIGNATURE OF REGISTRAR
12. DATE OF DEATH
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MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

8965

1. PLACE OF DEATH o. COUNTY <u>Q. A.</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>aa</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. LENGTH OF STAY IN 1b <u>Bay Ridge</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>A. G. General Hospital</u>			d. STREET ADDRESS <u>Upshur Road.</u>		
3. NAME OF DECEASED (Type or print) First <u>Marcus J.</u> Middle <u>Lucas</u> Last <u>Lucas</u>			4. DATE OF DEATH Month <u>9</u> Day <u>19</u> Year <u>1956</u>		
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 1, 1890</u>	9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Restaurant</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>		11. BIRTHPLACE (State or foreign country) <u>Greece</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>MRS. EVA. LUCAS</u> Address <u>#2</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart disease</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>					INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u> </u>	(County) <u> </u>	(State) <u> </u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>E. L. Inhardt</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/20/56</u>	
EXAMINER'S NAME (Type) <u>E. L. Inhardt</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-21-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St James</u>	22d. LOCATION (City, town, or county) <u>Pasole</u>	(State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor Sons</u>		ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR <u> </u>	24b. REGISTRAR'S SIGNATURE <u>J. D. Smith</u>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED
SEP 26 1956
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 08979
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma ryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrill			c. LENGTH OF STAY IN 1b			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gambrill	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS Box 334		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MYER Middle Last LYNSKY				4. DATE OF DEATH FOUND Month Sept. Day 24 Year 19 56			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/10/06		9. AGE (In years last birthday) 60 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USAF (Ret.)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Boston, Massachusetts		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Morris Lynsky				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes <input checked="" type="checkbox"/> (If yes, give war or dates of service) 1942-1944		16. SOCIAL SECURITY NO. 0905677		17. INFORMANT Morris Lynsky		Address Dorchester, Mass.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 983x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> <p>(b)</p> <p>DUE TO (c)</p> </div> <div style="width: 65%;"> <p>Undetermined by autopsy Anamnestic data indicates multiple impacts to the face and head as cause of death</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Assaulted — beaten about the head					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9 14 1956 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Anne Arundel Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Russell S. Fisher				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/2/56		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia	
23. FUNERAL DIRECTOR'S SIGNATURE B. D. Gansky + Son				ADDRESS Wash., D. C. 3501 14th St., N. W.		24a. REC'D BY REGISTRAR DATE 2 1956	
				24b. REGISTRAR'S SIGNATURE H. M. Joyce			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

OCT 2 1956

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9000 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 3, 13 Film 205 10-11-56 et

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Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>A.A.Co.</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>A.A.Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAND BEACH</u>		c. LENGTH OF STAY IN 1b <u>WOODLAND BEACH</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Long Wood Rd.</u>		d. STREET ADDRESS <u>Long Wood Rd.</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>LOUIS L. MABE</u>		4. DATE OF DEATH Month Day Year <u>9 25 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>MAY 22 1889</u>
9. AGE (in years last birthday) <u>67</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>EMP. LUMBER Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>LUMBER</u>	
11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>JOSEPH STEVENS</u>		14. MOTHER'S MAIDEN NAME <u>MARY BLANCHE BOBT</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>JAMES C. MABE</u>		Address <u># 27</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer</u> <u>434.3</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Hidden</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>L. H. HART</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>9/28/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>9/28/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u>		ADDRESS <u>Annapolis, Md.</u>	
24a. REC'D BY REGISTRAR <u>[Signature]</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF MEDICAL EXAMINER		17. SIGNATURE OF JURY		18. SIGNATURE OF JURY	
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RECEIVED
OCT 2 1956
BUREAU V. S.

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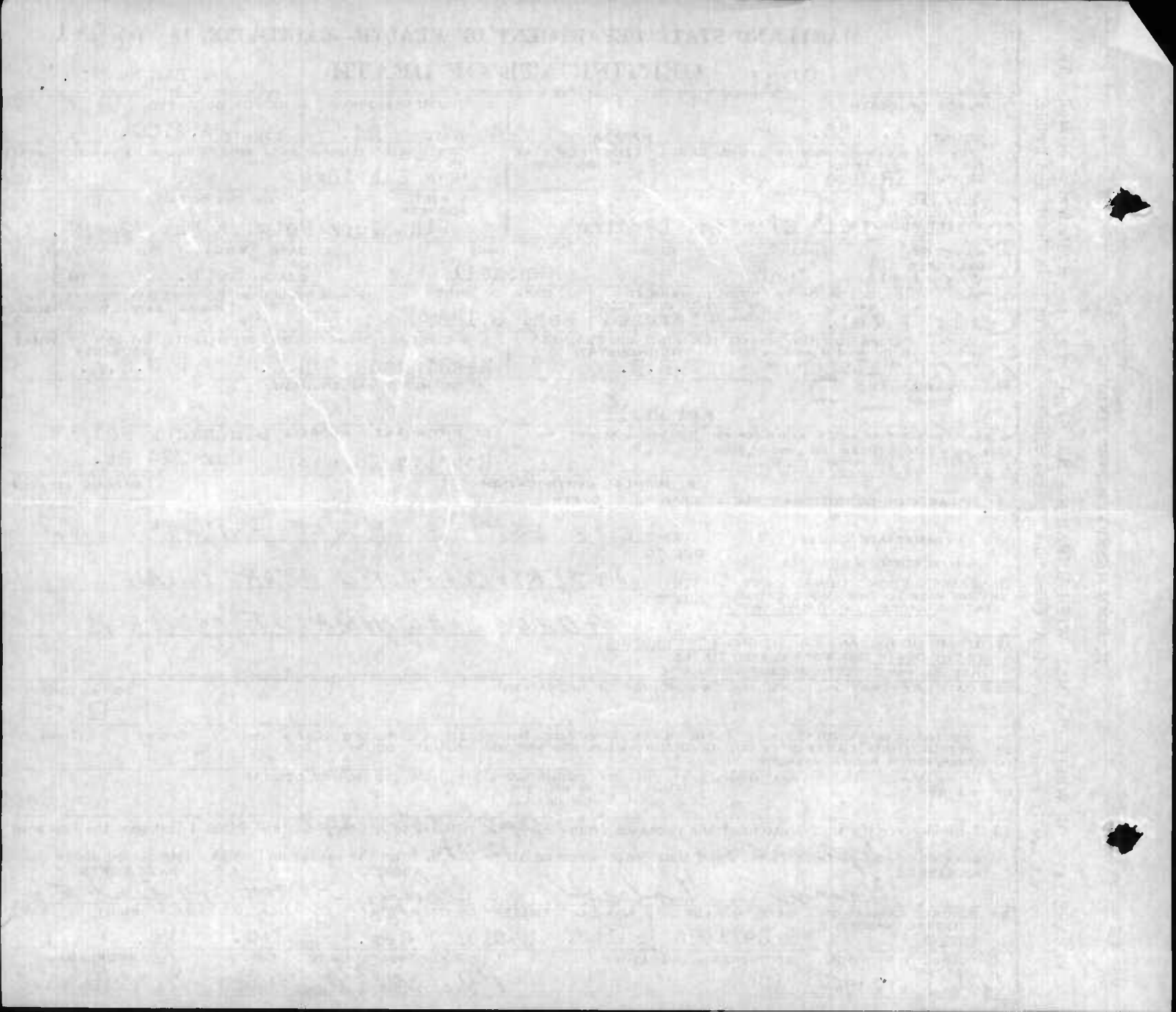
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY A.A.CO.	MARYLAND	STATE Md.	COUNTY A.A.CO.
CITY (If outside corporate limits, write RURAL and give nearest town) Elkridge Md.	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) Elkridge Md.	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Old Elkridge Landing		STREET ADDRESS (If rural give location) Linthicum Heights Box 224 Rt. 1	
3. NAME OF DECEASED: (First) (Middle) (Last) John Marshall		4. DATE (Month) (Day) (Year) OF DEATH: Sept. 12 1956	
5. SEX: Male	6. COLOR OR RACE: Col.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: Feb. 6, 1888
9. AGE last birthday 68 yrs.		IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10B. KIND OF BUSINESS OR INDUSTRY: P.R.R.	
11. BIRTHPLACE (State or foreign country): Washington D.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Marshall		14. MOTHER'S MAIDEN NAME: ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service) W.W.I.		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Rosetta Marshall Box 224 Rt. 1			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) CONGESTIVE HEART FAILURE			1 YR
ANTECEDENT CAUSE (S) (B) ARTERIOSCLEROTIC HEART DISEASE			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) ADENOCARCINOMA OF STOMACH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Sept. 11, 1955 to Sept. 11, 1956 , that I last saw the deceased alive on 11 Sept. 1956 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above.			
SIGNATURE George E. Gulean		ADDRESS M.D. Elkridge 27, md	
DATE SIGNED 14 Sept 56			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 9/24/1956	
NAME OF CEMETERY OR CREMATORY Balto. National Cem.		LOCATION (City, town, or county) (State) Balto. Md.	
DATE REC'D BY LOCAL REGISTRAR September 15 1956		REGISTRAR'S SIGNATURE R.W.	
FUNERAL DIRECTOR'S SIGNATURE Mrs. Ruth R. Williams		ADDRESS 822 N. Schreiner	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

CERTIFICATE OF DEATH

08982

Reg. Dist. No.

9902

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		STATE <u>M.D.</u> COUNTY <u>A.A.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cape St Clare</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cape St Clare</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cape St Clare</u>		LENGTH OF STAY (in this place) <u>6 Yrs.</u>		STREET ADDRESS (If rural give location) <u>River Bay Rd.</u>		STREET ADDRESS (If rural give location) <u>River Bay Rd. M.D.</u>	
3. NAME OF DECEASED (Type or Print) <u>Jane Rochester Meade</u>				4. DATE OF DEATH (Month) <u>9</u> (Day) <u>- 2</u> (Year) <u>- 56</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>Nov. 22 1894</u>	
9. AGE last birthday <u>61</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore M.D.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Frank K. Rochester</u>				14. MOTHER'S MAIDEN NAME <u>Lilly Goldsborough</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS <u>Husband, Rowland Meade</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Toxemia & Malnutrition</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO <u>Drug Reaction - Stomach</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO <u>Arthritis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Torticollis</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u>, 19<u>56</u>, to <u>2 Sept</u>, 19<u>56</u>, that I last saw the deceased alive on <u>28 Aug</u>, 19<u>56</u>, and that death occurred at <u>—</u> M, from the causes and on the date stated above.							
SIGNATURE <u>R. Hahn</u>				DATE SIGNED <u>Severna Park Md 9-2-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>9/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Bluff</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Md.</u>	
24. REC'D BY REGISTRAR <u>9/4/56</u>		REGISTRAR'S SIGNATURE <u>J. O. D. D. D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>J. M. T. T. T.</u>		ADDRESS <u>Annapolis, Md.</u>	

CERTIFICATE OF DEATH

Form 10-1-1

TO BE FILLED BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH

NAME OF DECEASED *John A. Smith* SEX *M* AGE *45* YEARS

RESIDENCE *1234 Main St., Baltimore, Md.*

DATE OF DEATH *Sept 4, 1956* PLACE OF DEATH *Home*

CAUSE OF DEATH *Myocardial Infarction*

IMMEDIATE CAUSE OF DEATH *Coronary Thrombosis*

PREVIOUS DISEASES *Arteriosclerosis, Hypertension*

DATE OF BIRTH *Aug 10, 1911* PLACE OF BIRTH *Baltimore, Md.*

EDUCATION *High School Graduate* OCCUPATION *Engineer*

RELIGION *Methodist* MARITAL STATUS *Married*

DATE OF MARRIAGE *June 15, 1938* NAME OF SPOUSE *John A. Smith*

DATE OF DEATH *Sept 4, 1956* PLACE OF DEATH *Home*

CAUSE OF DEATH *Myocardial Infarction*

IMMEDIATE CAUSE OF DEATH *Coronary Thrombosis*

PREVIOUS DISEASES *Arteriosclerosis, Hypertension*

DATE OF BIRTH *Aug 10, 1911* PLACE OF BIRTH *Baltimore, Md.*

EDUCATION *High School Graduate* OCCUPATION *Engineer*

RELIGION *Methodist* MARITAL STATUS *Married*

DATE OF MARRIAGE *June 15, 1938* NAME OF SPOUSE *John A. Smith*

DATE OF DEATH *Sept 4, 1956* PLACE OF DEATH *Home*

CAUSE OF DEATH *Myocardial Infarction*

IMMEDIATE CAUSE OF DEATH *Coronary Thrombosis*

PREVIOUS DISEASES *Arteriosclerosis, Hypertension*

DATE OF BIRTH *Aug 10, 1911* PLACE OF BIRTH *Baltimore, Md.*

EDUCATION *High School Graduate* OCCUPATION *Engineer*

BUREAU V. S.

SEP 5 1956

RECEIVED

200-100-100

8967

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First JOAN Middle E.N Last MEISEL				4. DATE OF DEATH Month September 1 Day 19 Year 56			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-1913		9. AGE (In years last birthday) 42 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY own home		11. BIRTHPLACE (State or foreign country) Germany		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Walter Koerschgen				14. MOTHER'S MAIDEN NAME Emily Brauhaus			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 041-03-8550		17. INFORMANT Harry H. Meisel- Husband- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia, both lower lobes 526x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Bronchiectasis, bilat. DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 12 hrs ?						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Atrophy of Pancreas due to gall stone blocking duct	
20a. ACCIDENT IT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/31/56 , to 9/1/56 , that I last saw the deceased alive on 9/3/56 , 19 56 , and that death occurred at 3:30 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Frank M Shipley M.D.				PHYSICIAN'S NAME (Type) Frank Shipley M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 4, 56		22c. NAME OF CEMETERY OR CREMATORY Hillcrest Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Hopping Funeral Home ADDRESS Annapolis, Md.				24a. REC'D BY REGISTRAR U. Branch REGISTRAR'S SIGNATURE DATE Sept 4, 56			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 5 1956

RECEIVED

8968

CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>908 Carrollton Ave.</i>		d. STREET ADDRESS <i>908 Carrollton Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Nannie Miller</i>		4. DATE OF DEATH Month <i>9</i> Day <i>14</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>5-30-1885</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>14</i> Hours <i>19</i> Min. <i>56</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Annapolis, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles Lee</i>		14. MOTHER'S MAIDEN NAME <i>Susie Larkins</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Ms Glenline Moore 908 Carrollton Ave</i>	
17. INFORMANT <i>Mrs Glenline Moore</i>		Address <i>908 Carrollton Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ascaris, carcinoma of</i> <i>199.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>240</i> (b) <i>Arteriosclerosis, Diabetes</i> DUE TO (c) <i>240</i>			INTERVAL BETWEEN ONSET AND DEATH <i>4 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-4-1948</i> , to <i>9-14-1956</i> , that I last saw the deceased alive on <i>9-11-1956</i> , and that death occurred at <i>10:57</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Edith Rodler</i> M.D.		ADDRESS (Street, city or town, state) <i>45 Franklin St, Annapolis, Md</i>	
PHYSICIAN'S NAME (Type) <i>Edith Rodler</i>		DATE SIGNED <i>45 Franklin St, Annapolis, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>9-15-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Brewer Hill</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II - Annapolis, Md</i>		ADDRESS <i>45 Franklin St, Annapolis, Md</i>	
24a. REC'D BY REGISTRAR <i>Wm. J. French</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

James Hamilton
908 Carrollton Ave
Baltimore
Md
Sept 14 1956
Charles the
Baltimore
Fengate Ct.
Marianne
Miller
Sept 14 1956
Baltimore, Md. 21202
John Hamilton

BUREAU V. A.

SEP 21 1956

RECEIVED

William Lee II - Baltimore
Sept 1-14-56 - 12 years old

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1

3903 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08985

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY in lb <u>5 hrs.?</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>in a car parked on Drumpoint Avenue.</u>				d. STREET ADDRESS <u>415 - 111 Avenue S.W.</u>			
3. NAME OF DECEASED (Type or print) <u>Earl McKinley Neall, Sr.</u>				4. DATE OF DEATH Month <u>September</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>4/1/07</u>		9. AGE (in years last birthday) <u>49 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self-Employed</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter R. Neall</u>				14. MOTHER'S MAIDEN NAME <u>Grace McKinley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-10-8058</u>		17. INFORMANT <u>Mr. Earl M. Neall Jr. (Son)</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>9/10/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>Sept. 12, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard V. Sington</u>				ADDRESS <u>Glen Burnie, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Seabury</u>	

RECEIVED

SEP 11 1956

BUREAU V. S.

9904

CERTIFICATE OF DEATH

Reg. Dist. No. 24

I. PLACE OF DEATH:

COUNTY

Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

TOWN Glen Burnie

LENGTH OF STAY (in this place)

5 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS

213 "C" St S.W.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Maryland

COUNTY

Balt.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

Baltimore 18

3401-4

STREET ADDRESS

(If rural give location)

109- E. 33rd St.

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

MARGARET ALMEDA NIE MEYER

4. DATE OF DEATH:

(Month)

(Day)

(Year)

Sept. 13 1956

5. SEX:

F

6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

Wid

8. DATE OF BIRTH:

12 February 1888

9. AGE last birthday:

68 yrs.

10. IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

Seamstress

10b. KIND OF BUSINESS OR INDUSTRY:

Clothing

11. BIRTHPLACE (State or foreign country):

Widditton, Pa

12. CITIZEN OF WHAT COUNTRY?

U.S.

13. FATHER'S NAME:

John Dunkel (dec)

14. MOTHER'S MAIDEN NAME:

Mrs Sadie Stipo (dec)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

no

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Mrs Frances Werner (daughter) 233-C St S.W. Glen Burnie

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause

(a)

acute coronary thrombosis

DUE TO

Interval Between Onset And Death

5 days

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

arteriosclerotic heart disease

DUE TO

3 yrs

(c)

Hypertension

4 yrs

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION:

0 none

19b. MAJOR FINDINGS OF OPERATION

none

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

no

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED

While at

Not While

Work ☐At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 19....., to 19....., that I last saw the deceased

alive on 19....., and that death occurred at 8:15 AM, from the causes and on the date stated above.

H.F. Manzyak M.D.

901 Edgely Rd, Glen Burnie, Md

ADDRESS

DATE SIGNED 13 Sept 1956

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

Sept. 17, 1956

NAME OF CEMETERY OR CREMATORY

Baltimore Cemetery

LOCATION (City, town, or county)

Baltimore

(State)

Md.

DATE REC'D BY LOCAL REGISTRAR

Sept - 17, 1956

REGISTRAR'S SIGNATURE

L. J. De Alba

24. FUNERAL DIRECTOR

L. J. De Alba

ADDRESS

Glen Burnie, Md.

Note: Patient had an acute coronary one week ago & was under the regular care of Dr Leon Perry & Glen Burnie.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

SEP 18 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08987

9905 CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundell</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundell</u>		STATE <u>Maryland</u>	
CITY (If outside corporate limits, write RURAL or town and give nearest town) <u>Drury</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Drury</u>		LENGTH OF STAY (in this place)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Annie</u> (First) <u>Owens</u> (Last)				4. DATE OF DEATH <u>9</u> (Month) <u>3</u> (Day) <u>1956</u> (Year)			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>7-15-1867</u>	9. AGE last birthday <u>89</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Lothian, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Stephen Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Jane Richardson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, thank.) <u>No</u> (If Yes, give year or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Cornelia H. Johnson - Lothian, Md.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Cerebral thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO <u>generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>hypertension</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> A. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> et work Not while <input type="checkbox"/> et work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 10</u> , 19 <u>55</u> , to <u>July 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>July 1</u> , 19 <u>56</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Emily H. Wilson</u>				ADDRESS (Street, city, town, state) <u>Lothian, Md.</u>		DATE SIGNED <u>7/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>9-6-56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt Zion</u>		LOCATION (City, town, or county) (State) <u>Lothian, Md</u>	
24. REC'D BY REGISTRAR <u>SEP 7 1956</u>		REGISTRAR'S SIGNATURE <u>Eda Belle Dent</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese - Annapolis, Md.</u>		ADDRESS	

SHORT PRINTING

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON HAVING KNOWLEDGE OF THE CAUSE OF DEATH. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, CITY OF BOSTON, MASSACHUSETTS, AND A COPY OF IT IS TO BE FURNISHED TO THE FUNERAL HOME OR TO THE PERSON IN CHARGE OF THE BURIAL. IT IS TO BE FILED IN THE OFFICE OF THE REGISTRAR OF DEATHS, CITY OF BOSTON, MASSACHUSETTS, AND A COPY OF IT IS TO BE FURNISHED TO THE FUNERAL HOME OR TO THE PERSON IN CHARGE OF THE BURIAL.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON, 1956

1. LOCAL WHERE OF DECEASED

2. PLACE OF DEATH

3. NAME OF DECEASED

4. SEX

5. AGE

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

BUREAU V. 1

SEP 2 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 FilmG201 9-28-56 et
9906 CERTIFICATE OF DEATH

08988
28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL CROWNSVILLE MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 33 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNSVILLE STATE			d. STREET ADDRESS unk.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM H. PHILLIPS			4. DATE OF DEATH Month Day Year 9 17 19 56		
5. SEX MALE	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unk.		9. AGE (In years last birthday) yrs. 78?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter		10b. KIND OF BUSINESS OR INDUSTRY - - - - -		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Robert Williams			14. MOTHER'S MAIDEN NAME Mary Phillips		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk.		16. SOCIAL SECURITY NO. unk.		17. INFORMANT Address Hospital records - Crownsville State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Crownsville, Md. INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal Pneumonia 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Prostate with metastasis DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) - - - - -		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. - - - - - 12		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) - - - - -	
20f. (City or town) - - - - -		20g. (County) - - - - -		20h. (State) - - - - -	
21. I certify that I attended the deceased from 10-15-23 , 19 56 , to 9-17- , 19 56 , that I last saw the deceased alive on 9-17- , 19 56 , and that death occurred at 9:40 p.m. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Crownsville State Hospital 9-18-56					
ACTUAL SIGNATURE Lionel McHenry Mapp			M.D. Crownsville State Hospital		
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp			Crownsville, Maryland		
22a. BURIAL, CREMATION, REMOVAL (Specify) 13		22b. DATE THEREOF 9-20-56		22c. NAME OF CEMETERY OR CREMATORY Mount Vernon	
22d. LOCATION (City, town, county) (State) Baltimore		22e. LOCATION (City, town, county) (State) Frederick			
23. FUNERAL DIRECTOR'S SIGNATURE Samuel V. Sullivan			ADDRESS Baltimore		
24a. REC'D BY REGISTRAR R. M. Joyce			24b. REGISTRAR'S SIGNATURE R. M. Joyce		

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESS</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CORONER</p>		<p>16. SIGNATURE OF REGISTRAR</p>	

BUREAU V. 1

SEP 21 1956

RECEIVED

TO REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

69939

9907

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 6yrs.11mos.17days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. STREET ADDRESS Not listed	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First John Middle Redson Last Redson		4. DATE OF DEATH Month 9 Day 25 Year 1956	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Unk. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/84
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months - Days - Hours - Min. -	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME John Redson		14. MOTHER'S MAIDEN NAME Irene Reins	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		18. ADDRESS Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral cortical contusions and cerebral edema DUE TO (c) Dehydration and malnutrition			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Dehydration and malnutrition			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/30 , 19 56 , to 9/25 , 19 56 , that I last saw the deceased alive on 9/25 , 19 56 , and that death occurred at 4:15 p.m. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 9/28/56			
ACTUAL SIGNATURE Lionel McHenry Mapp		M.D. Crownsville, Md.	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp			
22a. BURIAL, CREMATION, REMOVAL (Specify) 10/5/56		22b. DATE THEREOF 10/5/56	
22c. NAME OF CEMETERY OR CREMATORY Crownsville State Hospital Crownsville Md		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph H. Meng M.D. Crownsville Md		24a. REC'D BY REGISTRAR 10-8-56	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Nelson		45		Male		White		10/11/56		Home	
Cause of Death		Immediate Cause		Intermediate Cause		Underlying Cause		Manner of Death		Occupation	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Natural		Farmer	
Place of Birth		Date of Birth		Date of Admission		Date of Discharge		Date of Death		Date of Burial	
Iowa		10/11/11		10/11/56		10/11/56		10/11/56		10/11/56	
Hospital Name		Physician Name		Physician License No.		Physician Address		Physician City		Physician State	
St. Joseph's Hospital		Dr. J. H. Smith		12345		123 Main St.		Des Moines		Iowa	
Signature of Physician		Signature of Registrar		Signature of Coroner		Signature of Medical Examiner		Signature of Death Certifier		Signature of Burial Certifier	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 8

OCT 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9008

CERTIFICATE OF DEATH

Reg. Dist. No.

089889
28

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 3mos. 20days			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City				3501.4			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 1510 McCulloh Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print)		First Edward Middle Clark Last Ridgley		4. DATE OF DEATH		Month 9 Day 30 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/14/77	9. AGE (In years last birthday) yrs. 79	IF UNDER 1 YEAR IF UNDER 24 HRS. Months — Days — Hours — Min. —		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Unk.		10b. KIND OF BUSINESS OR INDUSTRY — — —		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Not given				14. MOTHER'S MAIDEN NAME Not given			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> Yes <input type="checkbox"/> WWI		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Crownsville State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic Pneumonia 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) — — —							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6/10 , 19 56 , to 9/30 , 19 56 , that I last saw the deceased alive on 9/30 , 19 56 , and that death occurred at 7:15p. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 10/1/56							
ACTUAL SIGNATURE Ludwig Benedict M.D.				PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 10/4/56		22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		22d. LOCATION (City, town, or county) (State) Baltimore City	
23. FUNERAL DIRECTOR'S SIGNATURE Philip J. Phillips ADDRESS 180871.240000 St.				24a. REC'D BY REGISTRAR OCT 8 1956		24b. REGISTRAR'S SIGNATURE H. M. Joyce	

CERTIFICATE OF DEATH

1. NAME OF DECEASED John Doe		2. SEX Male		3. AGE 35		4. DATE OF BIRTH Jan 15, 1900		5. PLACE OF BIRTH Baltimore, Md.	
6. OCCUPATION Teacher		7. MARITAL STATUS Married		8. EDUCATION High School		9. RELIGION Roman Catholic		10. RACE White	
11. DECEASED AT Home		12. PLACE OF DEATH Baltimore, Md.		13. DATE OF DEATH Oct 10, 1956		14. TIME OF DEATH 10:30 AM		15. CAUSE OF DEATH Heart Disease	
16. DISEASE OR INJURY Coronary Artery Disease		17. PERIOD OF ILLNESS 2 weeks		18. PRESENT ILLNESS Angina Pectoris		19. PREVIOUS ILLNESSES Hypertension		20. MEDICAL HISTORY None	
21. SIGNATURE OF PHYSICIAN J. A. Smith, M.D.		22. SIGNATURE OF DECEASED John Doe		23. SIGNATURE OF WITNESS Jane Doe		24. SIGNATURE OF DECEASED John Doe		25. SIGNATURE OF WITNESS Jane Doe	
26. SIGNATURE OF DECEASED John Doe		27. SIGNATURE OF WITNESS Jane Doe		28. SIGNATURE OF DECEASED John Doe		29. SIGNATURE OF WITNESS Jane Doe		30. SIGNATURE OF DECEASED John Doe	

BUREAU V. 3

OCT 9 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										08990	
Item 20 Film G204 10-5-56										Reg. Dist. No. 24	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ston Burnie</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>None</u>						d. STREET ADDRESS <u>1003 S. Park St</u>					
3. NAME OF DECEASED (Type or print) First <u>Delores</u> Middle <u>Robinson</u> Last <u>Robinson</u>						4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>1956</u>					
5. SEX <u>F</u>		6. COLOR OR RACE <u>C</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sent. 4th. 1939</u>		9. AGE (In years last birthday) <u>17</u> yrs.		IF UNDER 1 YEAR Months <u>17</u> Days <u>17</u> Hours <u>17</u> Min. <u>17</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>				11. BIRTHPLACE (State or foreign country) <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Reinh Robinson</u>						14. MOTHER'S MAIDEN NAME <u>Ruth Norris</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Mary Banks 603 S. Park St</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Skull Fracture</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Ablution of Skull & Brain</u> (c) <u>None</u> DUE TO (a) stating the underlying cause last.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Passenger in auto collision</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u>1:45</u> o. m. <u>9/15/56</u> 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Balto</u> (County) <u>Wash</u> (State) <u>Expressway A A Md.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>William V. Smith</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) <u>William V. Smith</u>						ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>9/19/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>				22d. LOCATION (City, town, or county) <u>Brooklyn Md</u> (State) <u>Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry O. Wilson</u>						24. REC'D BY REGISTRAR <u>SEP 20 1956</u> 24b. REGISTRAR'S SIGNATURE <u>L. J. Sedlitz</u>					

RECEIVED

SEP 26 1956

8969

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION The Anne Arundel General Hospital				d. STREET ADDRESS Ridge Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Katherine F. Sayles				4. DATE OF DEATH Month Day Year Sept. 20, 1956.			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 29, 1908	9. AGE (In years last birthday) 48 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Supervisor of Kitchen		10b. KIND OF BUSINESS OR INDUSTRY Reformatory for Women		11. BIRTHPLACE (State or foreign country) Mo.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Joseph Farrell				14. MOTHER'S MAIDEN NAME Emma Basso			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 491-10-0237		17. INFORMANT Joseph F. Sayles Address Ridge Rd. Pasadena, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion - Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 1/2 Days 10 YEARS.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) BEE STING 9/17/56 CAUSED ANAPHYLACTOID REACTION							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/17, 1956 , to 9/20, 1956 , that I last saw the deceased alive on 9/20, 1956 , and that death occurred at 4:20 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward S. Beck				ADDRESS (Street, city or town, state) 41 Southgate Ave, Annapolis Md			
PHYSICIAN'S NAME (Type) EDWARD S. BECK M.D.				DATE SIGNED 9/20/56			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-1956		22c. NAME OF CEMETERY OR CREMATORY Glen Haven		22d. LOCATION (City, town, or county) (State) Glen Burnie, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Edward Strong				ADDRESS 3207 W North Ave		24a. REC'D BY REGISTRAR DATE 9/24/56	
				24b. REGISTRAR'S SIGNATURE Wm. J. Lunscher			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED
SEP 24 1968

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorsey				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dorsey			
c. LENGTH OF STAY IN 1b 36Yrs.				d. STREET ADDRESS Forrest Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Forrest Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) William R. Schindele			4. DATE OF DEATH September 12 1956			5. SEX Male	
6. COLOR OR RACE White			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH April 12, 1883	
9. AGE (In years last birthday) 73 yrs.			10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter			10b. KIND OF BUSINESS OR INDUSTRY U.S. Government	
11. BIRTHPLACE (State or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY?			13. FATHER'S NAME Chris Schindele	
14. MOTHER'S MAIDEN NAME Marie Unknown			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 215-16-0981			17. INFORMANT Theresa Schindele Address Forrest Ave. Dorsey, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Haemorrhage - Hemiplegia 443X DUE TO (b) Hypertensive Cardio-Vas. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) 4 yrs.							INTERVAL BETWEEN ONSET AND DEATH 8 days
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Haemorrhage - approx - 4 yrs. ago							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I attended the deceased from 1959 , 19____, to 9/12/56 , 19____, that I last saw the deceased alive on 9/11/56 , 19____, and that death occurred at 12 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Frank E. Shipley M.D.				ADDRESS (Street, city or town, state) Savage, Ind. DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept 15, 1956		22c. NAME OF CEMETERY OR CREMATORY Meadowridge	
22d. LOCATION (City, town, or county) (State) Baltimore, Maryland				23. FUNERAL DIRECTOR'S SIGNATURE Ambrose, Inc. 1328 Sulphur Sp. Rd. ADDRESS			
24a. REC'D BY REGISTRAR SEP 14 1956				24b. REGISTRAR'S SIGNATURE Clara Hachup			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 11

James A. H. H. H.

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Chris Collins

SEP 14 1956

THE UNIVERSITY OF CHICAGO

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CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH o. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade</u>				c. LENGTH OF STAY IN 1b <u>3 1/2 Years</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U. S. Army Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELFRIEDA</u> Middle <u>ANNA</u> Last <u>SCHORK</u>				4. DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11 May 1925</u>	9. AGE (In years last birthday) yrs. <u>31</u>	IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.	IF UNDER 24 HRS. Months <u>1</u> Days <u>17</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>East Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Rep of Germany</u>				13. FATHER'S NAME <u>Unknown</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>Husband, T-2384A, Fort George G. Meade, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lung edema</u> <u>174X</u> DUE TO <u>Metastatic Cancer</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Metastatic Ca</u> DUE TO <u>Carcinoma of the uterus</u> (c) <u>Carcinoma of the uterus</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 Years</u> <u>1953</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>16 Sept 1956</u> to <u>17 Sept 1956</u> that I last saw the deceased alive on <u>16 Sept 1956</u> at <u>1010AM</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Laszlo Ambrus</u>				M.D. <u>USAH, Fort George G. Meade, Md.</u> DATE SIGNED <u>17 Sept 56</u>			
PHYSICIAN'S NAME (Type) <u>LASZLO AMBRUS, CAPT, MC.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>20 Sept 56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Cooke, Inc., Baltimore, Maryland</u>				24a. REC'D BY REGISTRAR <u>W.L. Saylor, 1st Lt, MSC</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

BUREAU A. S.

SEP 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 18 Film G205 1022/56 ams

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY ANNE ARUNDEL Crownsville MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE Maryland b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 26 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State			d. STREET ADDRESS unk.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) Mary First Middle Last Water Simms			4. DATE OF DEATH Month 9 Day 19 Year 19 56		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> unk. DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH unk.		9. AGE (In years lost birthday) 79? yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY -- -- -- -- --		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Ike Banks			14. MOTHER'S MAIDEN NAME Mary E. Banks		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. -- -- -- -- --		17. INFORMANT Hospital Records	
				Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Fibrillation DUE TO (b) (Cerebrovascular accident) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. CVA (Possible Thrombosis) DUE TO (c) 					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-29- 1930 , to 9-19- 19 56 , that I last saw the deceased alive on 9-19- 19 56 , and that death occurred at 12:40aM , from the causes and on the date stated above.					
ACTUAL SIGNATURE Lionel McHenry Mapp		M.D. Crownsville State Hospital		DATE SIGNED 9-19-56	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp, M.D. Crownsville, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF 9-20-56	22c. NAME OF CEMETERY OR CREMATORY Univ of Md. Medial Bldg		22d. LOCATION (City, town, or county) (State) Baltimore, Md
23. FUNERAL DIRECTOR'S SIGNATURE William Reese, II - Annapolis, Md		ADDRESS		24a. REC'D BY REGISTRAR 15 1956 24b. REGISTRAR'S SIGNATURE L. M. Joyce	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 13

100 101 102 103 104 105 106 107 108 109 110 111 112 113 114 115 116 117 118 119 120 121 122 123 124 125 126 127 128 129 130 131 132 133 134 135 136 137 138 139 140 141 142 143 144 145 146 147 148 149 150 151 152 153 154 155 156 157 158 159 160 161 162 163 164 165 166 167 168 169 170 171 172 173 174 175 176 177 178 179 180 181 182 183 184 185 186 187 188 189 190 191 192 193 194 195 196 197 198 199 200 201 202 203 204 205 206 207 208 209 210 211 212 213 214 215 216 217 218 219 220 221 222 223 224 225 226 227 228 229 230 231 232 233 234 235 236 237 238 239 240 241 242 243 244 245 246 247 248 249 250 251 252 253 254 255 256 257 258 259 260 261 262 263 264 265 266 267 268 269 270 271 272 273 274 275 276 277 278 279 280 281 282 283 284 285 286 287 288 289 290 291 292 293 294 295 296 297 298 299 300 301 302 303 304 305 306 307 308 309 310 311 312 313 314 315 316 317 318 319 320 321 322 323 324 325 326 327 328 329 330 331 332 333 334 335 336 337 338 339 340 341 342 343 344 345 346 347 348 349 350 351 352 353 354 355 356 357 358 359 360 361 362 363 364 365 366 367 368 369 370 371 372 373 374 375 376 377 378 379 380 381 382 383 384 385 386 387 388 389 390 391 392 393 394 395 396 397 398 399 400 401 402 403 404 405 406 407 408 409 410 411 412 413 414 415 416 417 418 419 420 421 422 423 424 425 426 427 428 429 430 431 432 433 434 435 436 437 438 439 440 441 442 443 444 445 446 447 448 449 450 451 452 453 454 455 456 457 458 459 460 461 462 463 464 465 466 467 468 469 470 471 472 473 474 475 476 477 478 479 480 481 482 483 484 485 486 487 488 489 490 491 492 493 494 495 496 497 498 499 500 501 502 503 504 505 506 507 508 509 510 511 512 513 514 515 516 517 518 519 520 521 522 523 524 525 526 527 528 529 530 531 532 533 534 535 536 537 538 539 540 541 542 543 544 545 546 547 548 549 550 551 552 553 554 555 556 557 558 559 560 561 562 563 564 565 566 567 568 569 570 571 572 573 574 575 576 577 578 579 580 581 582 583 584 585 586 587 588 589 590 591 592 593 594 595 596 597 598 599 600 601 602 603 604 605 606 607 608 609 610 611 612 613 614 615 616 617 618 619 620 621 622 623 624 625 626 627 628 629 630 631 632 633 634 635 636 637 638 639 640 641 642 643 644 645 646 647 648 649 650 651 652 653 654 655 656 657 658 659 660 661 662 663 664 665 666 667 668 669 670 671 672 673 674 675 676 677 678 679 680 681 682 683 684 685 686 687 688 689 690 691 692 693 694 695 696 697 698 699 700 701 702 703 704 705 706 707 708 709 710 711 712 713 714 715 716 717 718 719 720 721 722 723 724 725 726 727 728 729 730 731 732 733 734 735 736 737 738 739 740 741 742 743 744 745 746 747 748 749 750 751 752 753 754 755 756 757 758 759 760 761 762 763 764 765 766 767 768 769 770 771 772 773 774 775 776 777 778 779 780 781 782 783 784 785 786 787 788 789 790 791 792 793 794 795 796 797 798 799 800 801 802 803 804 805 806 807 808 809 810 811 812 813 814 815 816 817 818 819 820 821 822 823 824 825 826 827 828 829 830 831 832 833 834 835 836 837 838 839 840 841 842 843 844 845 846 847 848 849 850 851 852 853 854 855 856 857 858 859 860 861 862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000

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BUREAU V.

OCT 15 1956

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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9014 CERTIFICATE OF DEATH

Reg. Dist. No. *24*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>ANNE ARUNDEL</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>AA</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>HAWKINS POINT</i>		LENGTH OF STAY (in this place) Yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Hawkins Pt. Balto. 26, Md.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Hawkins Pt. Balto. 26, Md.</i>				STREET ADDRESS (If rural give location) <i>Hawkins Pt. Rd.</i>			
3. NAME OF DECEASED (Type or Print) <i>CATHERINE</i> (First) <i>SMITH</i> (Last)				4. DATE OF DEATH (Month) <i>Sept</i> (Day) <i>2</i> (Year) <i>1956</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>W</i>	8. DATE OF BIRTH <i>Oct 20, 1879</i>	9. AGE last birthday <i>76</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>Wickel</i>				14. MOTHER'S MAIDEN NAME <i>Unknown</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Family Same</i>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <i>450.0</i>				DISSECTING ANEURYSM			
ANTECEDENT CAUSE(S) DUE TO				OF AORTA			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				ARTERIOSCLEROSIS GENERAL			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				RHEUMATOID ARTHRITIS			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Aug 31, 1956</i> to <i>Sept 2, 1956</i> that I last saw the deceased alive on <i>Aug 31, 1956</i> and that death occurred at <i>9:15 A.M.</i> from the causes and on the date stated above. SIGNATURE <i>John M. Taler</i> ADDRESS (Street, city, town, state) <i>102 Balto - Hamp. Blvd. N.E. Green Spring, Md.</i> DATE SIGNED <i>9/2/56</i> M.D. <i>102 Balto - Hamp. Blvd. N.E. Green Spring, Md.</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>9/4/56</i>		NAME OF CEMETERY OR CREMATORY <i>Glen Haven Cem.</i>		LOCATION (City, town, or county) (State) <i>Balto., Md.</i>	
24. REC'D BY REGISTRAR <i>SEP 4 1956</i>		REGISTRAR'S SIGNATURE <i>L. G. Delaney</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>McGully Funeral Home 130 E. Fort Ave. #30</i>			

CERTIFICATE OF DEATH

1. DECEASED'S NAME (LAST, FIRST, MIDDLE)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF CORONER

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF BURIAL

15. SIGNATURE OF INTERMENT

16. SIGNATURE OF CREMATION

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

1. DECEASED'S NAME (LAST, FIRST, MIDDLE)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF CORONER

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF BURIAL

15. SIGNATURE OF INTERMENT

16. SIGNATURE OF CREMATION

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

BUREAU V. 81

SEP 4 1956

RECEIVED

MISSISSIPPI

CERTIFICATE OF DEATH

Reg. Dist. No.

21

8970

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>80 W. Washington St</u>				d. STREET ADDRESS <u>80 W. Washington St</u>			
3. NAME OF DECEASED (Type or print) <u>Esmond C. Smith</u>				4. DATE OF DEATH Month <u>9</u> Day <u>10</u> Year <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-20-1956</u>	9. AGE (In years last birthday) yrs. <u>4</u> Months <u>20</u>	10. IF UNDER 1 YEAR Months <u>4</u> Days <u>20</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md</u>	
13. FATHER'S NAME <u>Lewis Smith</u>				14. MOTHER'S MAIDEN NAME <u>Myrtle Parker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Myrtle Parker</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-Pneumonia (Primary)</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Acute Infantile Diarrhea</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I attended the deceased from <u>Sept 5</u> , 19 <u>56</u> , to <u>Sept 10</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept 10</u> , 19 <u>56</u> , and that death occurred at <u>3:01 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Rich. R. Anderson</u>				M.D. <u>H. C. G. Anderson, Md</u>			
PHYSICIAN'S NAME (Type) <u>DR. RICHARDSON MD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9-12-56</u>		<u>Brewer Hill</u>		<u>Annapolis, Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese, Jr.</u>				ADDRESS <u>Annapolis, Md</u>		24a. REC'D BY REGISTRAR <u>20 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		MARRIAGE <i>John Doe</i>	
AGE <i>45</i>		SEX <i>Male</i>	
DATE OF BIRTH <i>1910</i>		PLACE OF BIRTH <i>John Doe</i>	
OCCUPATION <i>John Doe</i>		CAUSE OF DEATH <i>John Doe</i>	
DATE OF DEATH <i>1956</i>		PLACE OF DEATH <i>John Doe</i>	
SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
SIGNATURE OF PHYSICIAN <i>John Doe</i>		SIGNATURE OF CLERK <i>John Doe</i>	

BUREAU V. A.

SEP 21 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9015

CERTIFICATE OF DEATH

08997
28

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 10 mos. 8 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				d. STREET ADDRESS 2671 Reiserstown Road			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Hubert Constantine Smith				4. DATE OF DEATH Month Day Year 9 12 19 56			
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Not given		9. AGE (In years last birthday) 78? yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tailor		10b. KIND OF BUSINESS OR INDUSTRY Unk.		11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Hubert Smith				14. MOTHER'S MAIDEN NAME Princess Mary Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk.		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Crownsville State Hospital Crownsville, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of Transverse Colon DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/4 , 19 55 to 9/12 , 19 56 , that I last saw the deceased alive on 9/11 , 19 56 , and that death occurred at 1 a. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE Ludwig Benedict				ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 9/12/56			
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) 9/14/56		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY Mt. Calvary		22d. LOCATION (City, town, or county) (State) Anne Arundel Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE E. O. Wilson				ADDRESS 1000 Brantley Ave.		24a. REC'D BY REGISTRAR SEP 17 1956	
				24b. REGISTRAR'S SIGNATURE H. M. Jones			

CERTIFICATE OF DEATH

<p>1. Name of deceased [Illegible]</p>		<p>2. Sex [Illegible]</p>	
<p>3. Date of birth [Illegible]</p>		<p>4. Place of birth [Illegible]</p>	
<p>5. Date of death [Illegible]</p>		<p>6. Place of death [Illegible]</p>	
<p>7. Cause of death [Illegible]</p>		<p>8. Manner of death [Illegible]</p>	
<p>9. Signature of physician [Illegible]</p>		<p>10. Signature of registrar [Illegible]</p>	
<p>11. Signature of informant [Illegible]</p>		<p>12. Date of registration [Illegible]</p>	

BUREAU V. 3

SEP 17 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08998

9016

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>?</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> 04X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u></u>				d. STREET ADDRESS <u></u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James B. Smith</u>				4. DATE OF DEATH Month Day Year <u>Sept. 25 1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 14, 1890</u> 66 yrs.		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Typing, & fishing</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>		11. BIRTHPLACE (State or foreign country) <u>Calvert Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James H. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Julia Dove</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Loy Mietzner</u> Address <u>Glen Burnie, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> <u>1420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>						INTERVAL BETWEEN ONSET AND DEATH <u>none</u> <u>2 MOS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>GLEN BURNIE, A.A., MD.</u>		20f. (City or town) (County) (State) <u>GLEN BURNIE, A.A., MD.</u>	
21. I certify that I attended the deceased from <u>8-27</u> , 19 <u>56</u> , to <u>9-25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9-10</u> , 19 <u>56</u> , and that death occurred at <u>3:00 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Leon C. Perry</u> M.D.				ADDRESS (Street, city or town, state) <u>201 BKA BLVD.</u>		DATE SIGNED <u>9-25-56</u>	
PHYSICIAN'S NAME (Type) <u>LEON C. PERRY, M.D.</u>				<u>GLEN BURNIE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 28 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Calvary</u>		22d. LOCATION (City, town, or county) (State) <u>Baratow, Calvert Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Harkness & Son - Mutual, Inc.</u>				ADDRESS <u></u>		24a. REC'D BY REGISTRAR DATE <u>SEP 28 1956</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. Schellhas</u>			

SEP 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9913

CERTIFICATE OF DEATH

Reg. Dist. No.

08994
28

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 53 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CROWNVILLE STATE HOSPITAL				d. STREET ADDRESS 113 Welcome Alley		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wilbur Middle Spence Last Spence				4. DATE OF DEATH Month 9 Day 22 Year 1956			
5. SEX M		6. COLOR OR RACE N		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 6, 1893	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 22 Days 15 Hours 56		IF UNDER 24 HRS. Months 22 Days 15 Hours 56			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Unknown		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME CHARLES SPENCE				14. MOTHER'S MAIDEN NAME MARY ?			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY THROMBOSIS DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) minutes							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 5:55							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)							
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 7/31 , 19 56 , to 9/22 , 19 56 , that I last saw the deceased alive on 9/21 , 19 56 , and that death occurred at 5:55 a. m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 9/22/56							
ACTUAL SIGNATURE L. Benedict M.D.							
PHYSICIAN'S NAME (Type) Ludwig Benedict, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/27/56		22c. NAME OF CEMETERY OR CREMATORY Baldwin National C.		22d. LOCATION (City, town, or county) (State) Baltimore City, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph L. Brown & Son 108 W. Montgomery St				24a. REC'D BY REGISTRAR SEP 26 1956		24b. REGISTRAR'S SIGNATURE R. M. Joyce	

5.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

9017

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

08999

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel Co</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewater P.O.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS JUNCTION</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Co. Home</u>		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MINNIE</u> Middle <u>STEINER</u> Last <u>SEDER</u>		4. DATE OF DEATH Month <u>SEPT.</u> Day <u>17</u> Year <u>1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 3 1871</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR: Months <u>84</u> Days <u>17</u> Hours <u>19</u> Min. <u>56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	11. BIRTHPLACE (State or foreign country) <u>ALEXANDRIA, Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>George F. Steiner</u>	
14. MOTHER'S MAIDEN NAME <u>AMANDA M. SINN</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>ANNAPOLIS JUNCTION, MD</u> <u>MRS MILDRED SEDER</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) <u>Arteriosclerotic C.V. Disease</u> DUE TO lying cause lost. (c) <u>no.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs.</u> <u>no.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NO</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. <u>5</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4/14</u> , 19 <u>54</u> , to <u>9/17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>9/17</u> , 19 <u>56</u> , and that death occurred at <u>10:30</u> P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Maurice F. Klawans</u> M.D.		ADDRESS (Street, city or town, state) <u>31 Southgate Av. Annapolis, Md 21402</u> DATE SIGNED <u>9/18/56</u>	
PHYSICIAN'S NAME (Type) <u>MAURICE F. KLAWANS</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept 20, 1956</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Savage Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Savage, Howard Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Robert Donahoe</u> ADDRESS <u>313 Talbot Ave Laurel, Md</u>		24a. REC'D BY REGISTRAR <u>SEP 22 1956</u> 24b. REGISTRAR'S SIGNATURE <u>J. O. Church</u>	

RECEIVED

SEP 26 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. TIME OF DEATH	
10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF REGISTRAR	
12. SIGNATURE OF WITNESS	
13. SIGNATURE OF DECEASED	
14. SIGNATURE OF NEXT OF KIN	
15. SIGNATURE OF BURIAL OFFICIAL	
16. SIGNATURE OF FUNERAL HOME	
17. SIGNATURE OF CEMETERY	
18. SIGNATURE OF CHURCH	
19. SIGNATURE OF MINISTERS	
20. SIGNATURE OF OTHERS	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9018
CERTIFICATE OF DEATH

Reg. Dist. No.

0900028

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville		c. LENGTH OF STAY IN 1b 16mos.25 days	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore City		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital	
d. STREET ADDRESS 1631 Ashland Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Wilbert Middle M. Last Stewart		4. DATE OF DEATH Month 9 Day 26 Year 19 56	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/31/96
9. AGE (In years last birthday) 59 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Unk.	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Thomas Stewart		14. MOTHER'S MAIDEN NAME Frances Stewart	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) Unk.		16. SOCIAL SECURITY NO. Unk.	
17. INFORMANT Hospital Records		Address Crownsville State Hospital Crownsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia and Left Hemiplegia			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 7/9 , 19 56 , to 9/26 , 19 56 , that I last saw the deceased alive on 9/26 , 19 56 , and that death occurred at 9:45a. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Crownsville, Md. DATE SIGNED 9/27/56			
ACTUAL SIGNATURE Lionel McHenry Mapp		M.D. Crownsville, Md.	
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/1/56	
22c. NAME OF CEMETERY OR CREMATORY Baltimore National Cem.		22d. LOCATION (City, town, or county) (State) 5501 Frederick Ave., Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph B. Rocks, Jr.		ADDRESS 1304 N. Center Ave.	
24a. REC'D BY REGISTRAR SEP 28 1956		24b. REGISTRAR'S SIGNATURE J. M. Joyce	

SEP 28 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G205 10-11-56 et

09001

CERTIFICATE OF DEATH

Reg. Dist. No.

21

8971

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>27 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Mildred</u> Middle <u>A-</u> Last <u>Swede</u>				4. DATE OF DEATH Month <u>September</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 5, 1898</u>	
9. AGE (In years last birthday) <u>58</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>17</u> Hours <u>17</u> Min.		IF UNDER 24 HRS.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Frank Forbeck</u>		14. MOTHER'S MAIDEN NAME <u>Lucinda Scott</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Charles George</u> Address <u>Cumberland, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic and Renal insufficiency</u> DUE TO (b) <u>following operation cholecystectomy</u> DUE TO (c) <u>Cirrhosis liver and cholelithiasis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Hepatomegaly, Jaundice, Bleeding Tendency</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u>		20c. TIME OF INJURY Month, Day, Year Hour a. m. — p. m. 19 <u>—</u>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>—</u>		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Aug 20</u> , 1956, to <u>Sept 17</u> , 1956, that I last saw the deceased alive on <u>Sept 17</u> , 1956, and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>Merton T. Waite</u>		ADDRESS (Street, city or town, state) <u>Cathedral & Deane Sts. Annapolis Md.</u>		DATE SIGNED <u>9-17-56</u>		PHYSICIAN'S NAME (Type)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-20-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. French</u>		ADDRESS <u>Abingdon, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 25 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Wm. J. French</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

09002
21

Reg. Dist. No.

8972

1. PLACE OF DEATH a. COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Anne Arundel General Hospital				d. STREET ADDRESS 195 Gloucester St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First ROBERT Middle WILLIAM Last TAYLOR				4. DATE OF DEATH Month SEPTEMBER Day 8 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 21, 1887		9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months 68 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Proprietor		10b. KIND OF BUSINESS OR INDUSTRY Retail Bar		11. BIRTHPLACE (State or foreign country) Annapolis, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lemuel K. Taylor				14. MOTHER'S MAIDEN NAME Mary Ellen Readman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) no		17. INFORMANT Address Mrs Clara E. Taylor- Wife- same as # 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 3 hrs.							INTERVAL BETWEEN ONSET AND DEATH 3 hrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 11:25 PM		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/8 , 19 56 , to 9/8 , 19 56 , that I last saw the deceased alive on 9/8/56 , 19 56 , and that death occurred at 11:25 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 63 College Ave., Annapolis, Maryland DATE SIGNED 9/11/56							
ACTUAL SIGNATURE Frank M Shipley M.D.				DATE SIGNED 9/11/56			
PHYSICIAN'S NAME (Type) Frank Shipley MD				63 College Ave., Annapolis, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 11, 1956		22c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery		22d. LOCATION (City, town, or county) (State) Annapolis, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOPPING FUNERAL HOME Annapolis, Md.				24a. REC'D BY REGISTRAR DATE 9-11-56			

CERTIFICATE OF DEATH

STATE OF NEW YORK DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

BUREAU V. 8

SEP 13 1956

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8973

CERTIFICATE OF DEATH

09003

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Deale</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. A. General Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Joseph</i> Middle <i>E.</i> Last <i>Tyler</i>		4. DATE OF DEATH Month <i>9</i> Day <i>10</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col.</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-11-1886</i>
9. AGE (In years last birthday) <i>70</i> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Self-Employed</i>	
11. BIRTHPLACE (State or foreign country) <i>Deale, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Tyler</i>		14. MOTHER'S MAIDEN NAME <i>Ella Tyler</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>_____</i>	
17. INFORMANT <i>Kernell J. Tyler - Churchton, Md.</i>		Address <i>_____</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Posterior Myocardial Infarction</i> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>260X</i> (b) <i>Arterio-sclerotic Heart disease & old</i> DUE TO (c) <i>Arterio-lateral Septal Infarction</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Diabetes Mellitus; Renal atrophy</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>8/3/56</i> , 19 <i>56</i> , to <i>Sept 10</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Sept 10</i> , 19 <i>56</i> , and that death occurred at <i>5:15 A.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. L. Richardson</i>		ADDRESS (Street, city or town, state) <i>M.D. 10 - Clayton Annapolis, Md.</i>	
DATE SIGNED <i>9/11/56</i>			
PHYSICIAN'S NAME (Type) <i>R. L. Richardson M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>9-13-56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Tyler Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Deale, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, II</i>		ADDRESS <i>Annapolis, Md.</i>	
24a. REC'D BY REGISTRAR <i>SEP 20 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Wm. J. French</i>	

CERTIFICATE OF DEATH

8073

1. NAME OF DECEASED		2. SEX		3. AGE	
4. OCCUPATION		5. MARITAL STATUS		6. PLACE OF BIRTH	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	

10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF DECEASED		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF REGISTRAR	
16. SIGNATURE OF CLERK		17. SIGNATURE OF CHIEF CLERK		18. SIGNATURE OF ASSISTANT CLERK	
19. SIGNATURE OF DEPUTY CLERK		20. SIGNATURE OF CLERK		21. SIGNATURE OF CLERK	
22. SIGNATURE OF CLERK		23. SIGNATURE OF CLERK		24. SIGNATURE OF CLERK	
25. SIGNATURE OF CLERK		26. SIGNATURE OF CLERK		27. SIGNATURE OF CLERK	
28. SIGNATURE OF CLERK		29. SIGNATURE OF CLERK		30. SIGNATURE OF CLERK	
31. SIGNATURE OF CLERK		32. SIGNATURE OF CLERK		33. SIGNATURE OF CLERK	
34. SIGNATURE OF CLERK		35. SIGNATURE OF CLERK		36. SIGNATURE OF CLERK	
37. SIGNATURE OF CLERK		38. SIGNATURE OF CLERK		39. SIGNATURE OF CLERK	
40. SIGNATURE OF CLERK		41. SIGNATURE OF CLERK		42. SIGNATURE OF CLERK	
43. SIGNATURE OF CLERK		44. SIGNATURE OF CLERK		45. SIGNATURE OF CLERK	
46. SIGNATURE OF CLERK		47. SIGNATURE OF CLERK		48. SIGNATURE OF CLERK	
49. SIGNATURE OF CLERK		50. SIGNATURE OF CLERK		51. SIGNATURE OF CLERK	
52. SIGNATURE OF CLERK		53. SIGNATURE OF CLERK		54. SIGNATURE OF CLERK	
55. SIGNATURE OF CLERK		56. SIGNATURE OF CLERK		57. SIGNATURE OF CLERK	
58. SIGNATURE OF CLERK		59. SIGNATURE OF CLERK		60. SIGNATURE OF CLERK	
61. SIGNATURE OF CLERK		62. SIGNATURE OF CLERK		63. SIGNATURE OF CLERK	
64. SIGNATURE OF CLERK		65. SIGNATURE OF CLERK		66. SIGNATURE OF CLERK	
67. SIGNATURE OF CLERK		68. SIGNATURE OF CLERK		69. SIGNATURE OF CLERK	
70. SIGNATURE OF CLERK		71. SIGNATURE OF CLERK		72. SIGNATURE OF CLERK	
73. SIGNATURE OF CLERK		74. SIGNATURE OF CLERK		75. SIGNATURE OF CLERK	
76. SIGNATURE OF CLERK		77. SIGNATURE OF CLERK		78. SIGNATURE OF CLERK	
79. SIGNATURE OF CLERK		80. SIGNATURE OF CLERK		81. SIGNATURE OF CLERK	
82. SIGNATURE OF CLERK		83. SIGNATURE OF CLERK		84. SIGNATURE OF CLERK	
85. SIGNATURE OF CLERK		86. SIGNATURE OF CLERK		87. SIGNATURE OF CLERK	
88. SIGNATURE OF CLERK		89. SIGNATURE OF CLERK		90. SIGNATURE OF CLERK	
91. SIGNATURE OF CLERK		92. SIGNATURE OF CLERK		93. SIGNATURE OF CLERK	
94. SIGNATURE OF CLERK		95. SIGNATURE OF CLERK		96. SIGNATURE OF CLERK	
97. SIGNATURE OF CLERK		98. SIGNATURE OF CLERK		99. SIGNATURE OF CLERK	
100. SIGNATURE OF CLERK		101. SIGNATURE OF CLERK		102. SIGNATURE OF CLERK	

BUREAU V. 1

SEP 21 1956

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

09004

8974

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>U.S. Naval Hospital</u>		d. STREET ADDRESS <u>77 Prince George St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Henry</u> Middle <u>Wilson</u> Last <u>WAHAB</u>		4. DATE OF DEATH Month <u>September</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Cau</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-18-70</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S.N. Ret.</u>		11. BIRTHPLACE (State or foreign country) <u>N.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>US</u>
13. FATHER'S NAME <u>William Wahab</u>		14. MOTHER'S MAIDEN NAME <u>Molsey Gaskins</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or date of service) <u>yes 1896-1926</u>		16. SOCIAL SECURITY NO. <u>1896-1926</u>	
17. INFORMANT <u>NAVAL HOSPITAL RECORDS</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia, suppurative</u> <u>916.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Burns, face, arm and trunk</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>8 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>BedClothes caught on fire</u>	
20c. TIME OF INJURY Month, Day, Year <u>11 a.m. Aug 29 1956</u>	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Annapolis AA Md</u>

21. I certify that I attended the deceased from 8-29-56, 19 56, to 9-6, 19 56, that I last saw the deceased alive on 9-6, 19 56, and that death occurred at 1109 A.M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED

ACTUAL SIGNATURE P. O. Lieb M.D.
PHYSICIAN'S NAME (Type) P.O. GILB CDR MC USN

22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>9/9/56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST. MARYS</u>	22d. LOCATION (City, town, or county) (State) <u>Annapolis Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Toth + Sons</u>		24a. REC'D BY REGISTRAR DATE <u>9/11/56</u>	24b. REGISTRAR'S SIGNATURE <u>P. O. Lieb</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SEP 13 1955

BUREAU V. S.

SEP 13 1955

X

X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9019

CERTIFICATE OF DEATH

09005

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY AR.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brooklyn Pk.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 222 Audrey Ave.		d. STREET ADDRESS 222 Audrey Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Bernard Middle H. Last Walenson		4. DATE OF DEATH Month 9 Day 22 Year 19 56	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/10/79
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY self	
11. BIRTHPLACE (State or foreign country) Norway		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. Family	
17. INFORMANT Family		Address Same	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 181X DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Heart Disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 2 , 19 53 , to 22 Sep , 19 56 , that I last saw the deceased alive on 22 Sep , 19 56 , and that death occurred at 8 A.M. , from the causes and on the date stated above.			
ACTUAL SIGNATURE Reynard Berdam M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 5010 Ritchie Hwy 22 Sep 56	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/25/56	
22c. NAME OF CEMETERY OR CREMATORY Cedar Hill		22d. LOCATION (City, town, or county) (State) Baltimore	
23. FUNERAL DIRECTOR'S SIGNATURE McCully Funeral Home		ADDRESS 130 East Fort Ave. #30	
24a. REC'D BY REGISTRAR DATE 25 1956		24b. REGISTRAR'S SIGNATURE John H. Hester	

CERTIFICATE OF DEATH

1. NAME OF DECEASED Brooklyn		2. SEX Male		3. AGE 35		4. DATE OF BIRTH 1921		5. PLACE OF BIRTH Brooklyn, N.Y.		6. OCCUPATION Police	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1945		9. PLACE OF MARRIAGE Baltimore, Md.		10. NAME OF SPOUSE Brooklyn		11. OCCUPATION OF SPOUSE Police		12. DATE OF DEATH 1956	
13. PLACE OF DEATH Baltimore, Md.		14. CAUSE OF DEATH Heart Disease		15. MANNER OF DEATH Natural		16. MEDICAL HISTORY None		17. PREVIOUS ILLNESS None		18. SIGNATURE OF PHYSICIAN [Signature]	
19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF WITNESS [Signature]		21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF WITNESS [Signature]		23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF WITNESS [Signature]	

BUREAU V. 3

SEP 25 1956

RECEIVED

9020

CERTIFICATE OF DEATH

09006

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Anne Arundel			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendship				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION - - - -				d. STREET ADDRESS Friendship			
3. NAME OF DECEASED (Type or print) First Frank Luther Middle Wells Last				4. DATE OF DEATH Month September Day 16 Year 1956			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 8, 1883	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months _____ Days _____		IF UNDER 24 HRS. Hours _____ Min. _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm Owner		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? Maryland							
13. FATHER'S NAME William T. Wells				14. MOTHER'S MAIDEN NAME Miranda Ward			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) - - - -				16. SOCIAL SECURITY NO. - - - -		17. INFORMANT Mrs. Ethel Wells Address Owings, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Stomach 151X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from January , 19 56 , to August , 19 56 , that I last saw the deceased alive on 9 , 19 56 , and that death occurred at 9 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) St. Leonard, Maryland DATE SIGNED 9/17/56 ACTUAL SIGNATURE R. D. Villarreal M.D. PHYSICIAN'S NAME (Type) R. D. Villarreal							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF Sept 19, 1956		22c. NAME OF CEMETERY OR CREMATORY Friendship Cemetery	
22d. LOCATION (City, town, or county) Friendship				22e. (State) Maryland			
23. FUNERAL DIRECTOR'S SIGNATURE W. H. Hutchins				ADDRESS Owings		24a. REC'D BY REGISTRAR DATE 9/19/56	
24b. REGISTRAR'S SIGNATURE Elsie West							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1956

Name of Deceased		Age		Sex		Race		Date of Birth		Date of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar	
John Doe		45		Male		White		1911		1956		Boston		Heart Disease		Natural		[Signature]		[Signature]	
Occupation		Education		Marital Status		Religion		Usual Residence		Usual Address		Usual Telephone		Usual Hospital		Usual Physician		Usual Nurse		Usual Doctor	
Teacher		High School		Married		Catholic		Boston		123 Main St		123-4567		St. Mary's		Dr. Smith		Mrs. Jones		Dr. Brown	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Cause of Death	
1956		10:00 AM		Boston		Heart Disease		Natural		[Signature]		[Signature]		1956		10:00 AM		Boston		Heart Disease	
Date of Death		Time of Death		Place of Death		Cause of Death		Manner of Death		Signature of Physician		Signature of Registrar		Date of Death		Time of Death		Place of Death		Cause of Death	
1956		10:00 AM		Boston		Heart Disease		Natural		[Signature]		[Signature]		1956		10:00 AM		Boston		Heart Disease	

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SEP 25 1956
BUREAU V. 1

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9221

CERTIFICATE OF DEATH

09007

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crownsville				c. LENGTH OF STAY IN 1b 13 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Crownsville State Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Eugene Middle Walter Last White				4. DATE OF DEATH Month 9 Day 25 Year 19 56			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 5/1/70	
9. AGE (In years lost birthday) 86 yrs.		IF UNDER 1 YEAR Months — Days — Hours — Min. —		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Pastor		10b. KIND OF BUSINESS OR INDUSTRY Pastor	
11. BIRTHPLACE (State or foreign country) Texas				12. CITIZEN OF WHAT COUNTRY? U. S.			
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Unk.		17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis, Myocardial Failure (c) Chronic Brain Syndrome				INTERVAL BETWEEN ONSET AND DEATH 17 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic Pneumonia							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Crownsville, Md.				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from 9/24 , 19 56 to 9/25 , 19 56 , that I last saw the deceased alive on 9/25 , 19 56 and that death occurred at 11:00 a.m. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Lionel McHenry Mapp				DATE SIGNED 9/25/56			
PHYSICIAN'S NAME (Type) Lionel McHenry Mapp				ADDRESS (Street, city or town, state) Crownsville, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-29-56		22c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk		22d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Holland Funeral Home				24a. REC'D BY REGISTRAR DATE 2 1956		24b. REGISTRAR'S SIGNATURE H. M. Jones	

OCT 2 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9022 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09008

Reg. Dist. No. 20

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1st Dist. Mayo</u> c. LENGTH OF STAY IN lb <u>1 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Washington</u> b. COUNTY <u>D.C.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>B.C.</u> d. STREET ADDRESS <u>41 K Street, N.W.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>HARTWELL</u> Middle <u>WHITE</u> Last				4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>19 56</u>															
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 30, 1918</u>		9. AGE (In years last birthday) <u>38</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Streetcar op.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Transit</u>				11. BIRTHPLACE (State or foreign country) <u>Bertic County, N.C.</u>				12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Cleveland White</u>								14. MOTHER'S MAIDEN NAME <u>White</u>											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. <u>246 18 2719</u>				17. INFORMANT <u>Cedric D. Castellowe</u>				Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning (Presumed)</u> <u>(Body Found in Water)</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Apparently fell overboard</u>															
20c. TIME OF INJURY Month, Day, Year Hour <u>3</u> a. m. <u>9/2</u> 19 <u>56</u> p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Water</u>				20f. (City or town) <u>Chesapeake Bay - between West & South Rivers</u> (County) (State)									
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																			
ACTUAL SIGNATURE <u>Russell S. Fisher</u>				M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9/4/56</u>											
EXAMINER'S NAME (Type) <u>Russell S. Fisher</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>											
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removal</u>				22b. DATE THEREOF <u>Sept 4 1956</u>				22c. NAME OF CEMETERY OR CREMATORY <u>Byrd & Walker Funeral Home</u>				22d. LOCATION (City, town, or county) (State) <u>WINDSOR</u> <u>N.C.</u>							
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>								ADDRESS <u>Galesville MD</u>				24a. REC'D BY REGISTRAR <u>DATE 9 10 56</u>				24b. REGISTRAR'S SIGNATURE <u>Carrie Smith</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the date, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

SEP 7 1956

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09009

Reg. Dist. No.

24

9023

1. PLACE OF DEATH a. COUNTY Anne Arundel b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Riviera Beach, (Pasadena) c. LENGTH OF STAY IN 1b 3 hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Stoney Creek		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodlawn, Baltimore 7 d. STREET ADDRESS 6502 Dogwood Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Charles David Widerman		4. DATE OF DEATH Month Day Year September 3rd 19 56	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/1901
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lakeshore, A.A.Co. Md.	11. BIRTHPLACE (State or foreign country) U.S.A.
13. FATHER'S NAME David P. Widerman		14. MOTHER'S MAIDEN NAME Caroline Euler	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-01-3241	
17. INFORMANT Mrs. Clara Ditman, (Sister)		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accidental Drowning DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH Sudden			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Could not swim and walked too far in Stoney Creek.	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 9/3/56 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Stoney Creek	20f. (City or town) (County) (State) Riviera Beach, A.A. Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>Gustave H. Faubert</i> EXAMINER'S NAME (Type) Gustave H. Faubert		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 9/3/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-7-1956	22c. NAME OF CEMETERY OR CREMATORY Lorraine Park	22d. LOCATION (City, town, or county) (State) Woodlawn Md.
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. Howard Strong</i> ADDRESS 3107 W. North Ave		24a. REC'D BY REGISTRAR SEP 5 1956	24b. REGISTRAR'S SIGNATURE <i>L. J. Sedberry</i>

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. This pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical history, cause of death, and examiner information. The text is mostly illegible due to the quality of the scan.

BUREAU V. S.

SEP 5 1956

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Handwritten text at the bottom of the page, possibly a signature or date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8975

CERTIFICATE OF DEATH

09010

Reg. Dist. No.

21

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u>3Y 01-4</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen. Hosp.</u>				d. STREET ADDRESS <u>2544 W. Lombard St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Williams</u> Middle <u>A.</u> Last <u>WILDASON</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH. <u>June 12-1888</u>	
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>		IF UNDER 24 HRS. Months <u>68</u> Days <u>68</u> Hours <u>68</u> Min. <u>68</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pipe Fitter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Federal Tin Co.</u>			
11. BIRTHPLACE (State or foreign country) <u>Md.</u>				12. CITIZEN OF WHAT COUNTRY? <u>Am.</u>			
13. FATHER'S NAME <u>John Wildason</u>				14. MOTHER'S MAIDEN NAME <u>Ellen Brunner</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216-14-3332</u>			
17. INFORMANT <u>Mrs. Leo Robbins</u>				Address <u>201 Mc Randree</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BASILAR ARTERY THROMBOSIS</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CEREBRAL ARTERIOSCLEROSIS</u> DUE TO (c) <u>5 yrs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 wks</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				(County)		(State)	
21. I certify that I attended the deceased from <u>August</u> , 19 <u>56</u> , to <u>Sept-17</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Sept-17</u> , 19 <u>56</u> , and that death occurred at <u>7:20</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>John L. Hederman</u> M.D.				ADDRESS (Street, city or town, state) <u>90 Cathedral St. Annapolis Md.</u>			
DATE SIGNED <u>9/18/56</u>							
PHYSICIAN'S NAME (Type) <u>Annapolis Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/20/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Lorraine</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore</u>	
23. GENERAL DIRECTOR'S SIGNATURE <u>Philip Herwig</u>				ADDRESS <u>2024 SLEP</u>			
24a. REC'D BY REGISTRAR <u>DATE 191956</u>				24b. REGISTRAR'S SIGNATURE <u>Wm. J. Lanza</u>			

CERTIFICATE OF DEATH

PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE		BALTIMORE	
DATE OF BIRTH		DATE OF DEATH	
JAN 1 1900		JAN 1 1900	
AGE		AGE	
10		10	
SEX		SEX	
MALE		MALE	
RACE		RACE	
WHITE		WHITE	
OCCUPATION		OCCUPATION	
STUDENT		STUDENT	
CAUSE OF DEATH		CAUSE OF DEATH	
DIPHTHERIA		DIPHTHERIA	
MANNER OF DEATH		MANNER OF DEATH	
NATURAL		NATURAL	
PLACE OF INTERMENT		PLACE OF INTERMENT	
BALTIMORE		BALTIMORE	
DATE OF INTERMENT		DATE OF INTERMENT	
JAN 1 1900		JAN 1 1900	
SIGNATURE OF PHYSICIAN		SIGNATURE OF PHYSICIAN	
J. H. BROWN		J. H. BROWN	
SIGNATURE OF REGISTRAR		SIGNATURE OF REGISTRAR	
J. H. BROWN		J. H. BROWN	

BUREAU V. 1

SEP 19 1956

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8976

CERTIFICATE OF DEATH

09011

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>M.D.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis M.D. 2 days</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Severna Park M.D.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel Gen Hosp.</u>				e. STREET ADDRESS <u>Cypress Creek R.D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Irene Agatha WOLF</u>				4. DATE OF DEATH Month Day Year <u>Sept. 29 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 16, 1889</u>	
9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>John Brady</u>				14. MOTHER'S MAIDEN NAME <u>Florence V. Houle?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT Address <u>Husband, Ed. R. Wolf, Same?</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Posterior Myocardial IN FArction</u> 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetes Mellitus</u> DUE TO (c) <u>8 yrs.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from: <u>1955</u> , 19____, to <u>1956</u> , 19____, that I last saw the deceased alive on <u>9-29-56</u> , 19____, and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert R. Hahn</u> M.D.				ADDRESS (Street, city or town, state) <u>Severna Park</u> DATE SIGNED <u>9-29-56</u>			
PHYSICIAN'S NAME (Type) <u>Robert R. Hahn M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Funeral</u>		22b. DATE THEREOF <u>Oct. 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard L. Slighter</u> ADDRESS <u>Elm - Burnie Rd.</u>				24a. REC'D BY REGISTRAR DATE <u>1956</u>		24b. REGISTRAR'S SIGNATURE <u>Am J. French</u>	

MEDICAL CERTIFICATION

BUREAU V. 4

OCT 3 1956

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THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION
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1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

9024 CERTIFICATE OF DEATH

09012

73

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Linthicum Hgts.</u>		<u>37 yrs.</u>		TOWN <u>Linthicum Heights</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>205 Laurel Road</u>				STREET ADDRESS (If rural give location) <u>205 Laurel Road</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Caldwell</u>		(Middle) <u>Woodruff</u>		(Last) <u>Woodruff</u>		(Month) (Day) (Year) <u>September 22, 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>April 18, 1882</u>	<u>74</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Physician (ret.)</u>		<u>Self Employed</u>		<u>North Carolina</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>George E. Woodruff</u>				<u>Betty Caldwell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>None</u>		<u>DeForest Woodruff</u> <u>1204 Northview Rd. Balto. 718, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
18a. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>20 yrs.</u>	
<u>422.1 IMMEDIATE CAUSE (A) <u>Cardio-Vascular Disease</u></u>							
<u>ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis</u></u>						<u>5 yrs.</u>	
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1938</u> <u>9/22/56</u> to <u>9/22/56</u> 19 <u>10:45 A.M.</u> that I last saw the deceased alive on <u>9/22/56</u> 19 <u>10:45 A.M.</u> and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Chas. L. Ball Jr.</u>		<u>Sept-25, 1956</u>		<u>Linthicum Md.</u>		<u>Balto., Md.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Burial</u>		<u>Dr. Caldwell Woodruff</u>		<u>W. H. Singleton</u>		<u>Glen Burnie, Md.</u>	
DATE							
<u>SEP 26 1956</u>							

CERTIFICATE OF DEATH

WESTLAND STATE HOSPITAL OF HEATH - BATHING 13

1956

Westland State

1. Name of deceased (Print or type)

2. Date of death

3. Place of death

4. Sex

5. Race

6. Age

7. Birth date

8. Birth place

9. Education

10. Occupation

11. Marital status

12. Cause of death

13. Immediate cause

14. Underlying cause

15. Contributing cause

16. Manner of death

17. Signature of physician

18. Signature of medical examiner

19. Signature of coroner

20. Signature of registrar

21. Signature of funeral director

22. Signature of family

23. Signature of witness

24. Signature of other

25. Signature of

26. Signature of

27. Signature of

28. Signature of

29. Signature of

30. Signature of

BUREAU V. S.

SEP 28 1956

RECEIVED

Reg. Dist. No.

9-25

VS A15C 1-55 10M

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY ANNE ARUNDEL	MARYLAND	STATE MARYLAND	COUNTY ANNA ARUNDEL
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BROOKLYN PARK	LENGTH OF STAY (in this place) 37Yrs	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BROOKLYN PARK	STREET ADDRESS (If rural give location) 4300 RITCHIE HIGHWAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4300 RITCHIE HIGHWAY		STREET ADDRESS (If rural give location) 4300 RITCHIE HIGHWAY	
3. NAME OF DECEASED (Type or Print) CORA BELLE YINGLING		4. DATE OF DEATH SEPT. 24 1956	
5. SEX F.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH AUG. 28, 1881
9. AGE last birthday 75 yrs.		10. IF UNDER 1 YEAR * IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if part time) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) BALTIMORE MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME NICHOLAS GEO. GROSS	
14. MOTHER'S MAIDEN NAME FLORENCE E. PALMER		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) NO	
16. SOCIAL SECURITY NO. NONE		17. INTERMEDIATE ADDRESS 3316 ST. AMBROSE AVE. MRS. PARKER W. GROSS	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 151X IMMEDIATE CAUSE (A) Carcinoma of Stomach ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. 904 Fracture of int. Hip	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) (Second) M. <input type="checkbox"/> A. <input type="checkbox"/>	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from June 15, 1950 to Sept 24, 1956 , that I last saw the deceased alive on 9/22, 1956 , and that death occurred at 11:10 A.M. from the causes and on the date stated above. SIGNATURE Samuel Rubin M.D. ADDRESS (Street, city, town, state) 2030 Patuxent One City, Md. DATE SIGNED SEP 26 1956			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 9/27/56	
NAME OF CEMETERY OR CREMATORY GREENMONT CEMETERY		LOCATION (City, town, or county) (State) BALTIMORE MARYLAND.	
24. REC'D BY REGISTRAR DATE SEP 26 1956		REGISTRAR'S SIGNATURE Ada Hutton	
25. FUNERAL DIRECTOR'S SIGNATURE HENRY SANDER & SONS INC.		ADDRESS BALTIMORE MARYLAND	

CERTIFICATE OF DEATH

NAME OF DECEASED

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

HEIGHT

WEIGHT

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

DATE OF DEATH

TIME OF DEATH

PLACE OF BIRTH

PLACE OF DEATH

PLACE OF BURIAL

NAME OF PHYSICIAN

NAME OF NURSE

NAME OF MINISTER

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

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SEP 27 1956

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